

12623 Item 21 Film G235 11-17-58 et 12598 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 41 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Tennessee b. COUNTY Knoxville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 79x-3 d. STREET ADDRESS 2300 Magnolia Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Ollice Lucille Akard			4. DATE OF DEATH Month Day Year November 5, 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 7, 1906		9. AGE (In years last birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Robert N. Caldwell		
14. MOTHER'S MAIDEN NAME Pearl Simms			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 415-50-7493			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 271.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Parathyroid Adenoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X					INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 3 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 25, 1958 to November 5, 1958 , that I last saw the deceased alive on November 5, 1958 , and that death occurred at 8:19 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-6-58 ACTUAL SIGNATURE Leon I. Goldberg M.D. PHYSICIAN'S NAME (Type) Leon I. Goldberg, M. D. National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 11/8/58		22c. NAME OF CEMETERY OR CREMATORY Lynhurst Cemetery	
22d. LOCATION (City, town, or county) (State) Knoxville, Tennessee		24a. REC'D BY REGISTRAR DATE NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12624 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN lb <u>33 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6812 Florida St.</u>			1. STREET ADDRESS <u>6812 Florida St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Joseph F. Alfaro</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>26</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-88</u>		9. AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Spain</u>	
13. FATHER'S NAME <u>Ramon Alfaro</u>			14. MOTHER'S MAIDEN NAME <u>Guadalupe Guastavino</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ruth M. Alfaro</u> Address <u>Ramona St. 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		ADDRESS <u>Washington, D. C.</u>		22d. LOCATION (City, town, or county) (State) <u>Clinton, Mass.</u>	
24a. REC'D BY REGISTRAR <u>NOV 28 '58</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

DATE SIGNED

11-26-58

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1932

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: ☐ Natural ☐ Accidental ☐ Suicidal ☐ Homicidal

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Registrar: _____

15. Signature of Physician: _____

16. Signature of Nurse: _____

17. Signature of Undertaker: _____

18. Signature of Burial Place: _____

19. Signature of Funeral Home: _____

20. Signature of Cemetery: _____

21. Signature of Interment: _____

22. Signature of Burial: _____

23. Signature of Cremation: _____

24. Signature of Disposition: _____

25. Signature of Final Disposition: _____

26. Signature of Final Disposition: _____

27. Signature of Final Disposition: _____

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98. Signature of Final Disposition: _____

99. Signature of Final Disposition: _____

100. Signature of Final Disposition: _____

12625

CERTIFICATE OF DEATH

Reg. Dist. No.

12600

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xxxxxxxx Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6711 Georgia Street</u>		d. STREET ADDRESS <u>16711 Ga. St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Aubrey</u> Last <u>Allan</u>		4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N. E. A. Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Johns, New Brunswick USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William C Allan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Aubrey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-42-2720</u>	
17. INFORMANT <u>Mrs Izora S. Allan-Item#2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary atherosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>essential hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 4</u> , 19 <u>58</u> , to <u>Nov 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 3</u> , 19 <u>58</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>7852 16th St. NW</u>		DATE SIGNED <u>11/3/58</u>	
ACTUAL SIGNATURE <u>H. F. Kreuzburg</u>		M.D. <u>Wash DC</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>11/3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12626

CERTIFICATE OF DEATH

12601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>1 Mo</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>3248 Patterson St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bettie D.</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 25, 1861</u> 9. AGE (In years last birthday) <u>96</u> yrs.		4. DATE OF DEATH <u>Nov. 16</u> 19 <u>58</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u> 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Fayette De Val</u> 14. MOTHER'S MAIDEN NAME <u>Eliza Cook</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Miss Ruth Amiss- 3248 Patterson St. N.W.</u> Address <u>2006-85502</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis, advanced</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>5 yrs +</u> <u>10 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Occlusion August 1958</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , to <u>Nov 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>58</u> , and that death occurred at <u>7:15</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D. <u>3921 Ingomar St.</u> ADDRESS (Street, city or town, state) <u>Nov 16 '58</u> DATE SIGNED		PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> <u>Wash 15 D.C.</u>	
22a. BURIAL, CREMATION, or other disposition (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>NOV 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MINNESOTA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18
CERTIFICATE OF DEATH

15138

WILLIAM BRODIE

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
WILLIAM BRODIE		MALE		38		JAN 15 1880	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
NEW YORK CITY		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
JAN 15 1918		NEW YORK CITY		10:00 AM		100.0	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
TESTED BY		TESTED BY		TESTED BY		TESTED BY	
DATE OF TEST		DATE OF TEST		DATE OF TEST		DATE OF TEST	
PLACE OF TEST		PLACE OF TEST		PLACE OF TEST		PLACE OF TEST	
NAME OF PHYSICIAN		NAME OF PHYSICIAN		NAME OF PHYSICIAN		NAME OF PHYSICIAN	
DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION	
PLACE OF EXAMINATION		PLACE OF EXAMINATION		PLACE OF EXAMINATION		PLACE OF EXAMINATION	
NAME OF CLERK		NAME OF CLERK		NAME OF CLERK		NAME OF CLERK	
DATE OF ENTRY		DATE OF ENTRY		DATE OF ENTRY		DATE OF ENTRY	
PLACE OF ENTRY		PLACE OF ENTRY		PLACE OF ENTRY		PLACE OF ENTRY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12627

CERTIFICATE OF DEATH

12602

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9601 COLESVILLE Rd.</u>		d. STREET ADDRESS <u>19601 COLESVILLE Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>ANN</u> Last <u>ANDREWS</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15, 1864</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jules Etienne Dietsch</u>		14. MOTHER'S MAIDEN NAME <u>Elise Vuillamier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>son, John N. Andrews</u>		Address <u>MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Old age</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Oct 35</u> , 19 <u>35</u> , to <u>Nov. 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 17</u> , 19 <u>58</u> , and that death occurred at <u>8:35 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John N. Andrews</u>		ADDRESS (Street, city or town, state) <u>9601 Colesville Rd Silver Spring MD</u>	
DATE SIGNED <u>11-17-58</u>			
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov 19, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John N. Andrews</u>		ADDRESS <u>254 CARROLL ST NW.</u>	
24a. REC'D BY REGISTRAR <u>NOV 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

12598 Item 2 FilmG236 12-4-58 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

12603

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK MD		c. LENGTH OF STAY IN 1b 4 MO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OAK HAVEN REST HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY E AULT.		4. DATE OF DEATH Month Day Year 11/27/58 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/25/1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN KING		14. MOTHER'S MAIDEN NAME MARY E KING.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT EDMOND AULT.		Address WHEATON MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute myocardial failure arteriosclerotic heart disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) advanced cerebral arteriosclerosis - 5 yrs		INTERVAL BETWEEN ONSET AND DEATH sudden 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 5, 1958 to Nov 27, 1958 , that I last saw the deceased alive on Nov 27, 1958 , and that death occurred at 11:04 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel B. Washington M.D.		DATE SIGNED 6234 Balwe 2 W Wash DC 11/27/58	
PHYSICIAN'S NAME (Type) Daniel B. Washington MD		6234 G4 Ave NW Wash. DC.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/29/58	
22c. NAME OF CEMETERY OR CREMATORY ST JOHNS CEMETERY		22d. LOCATION (City, town, or county) (State) FOREST GLEN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Thompson		ADDRESS 3732 ...	
24a. REC'D BY REGISTRAR DEC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

12628

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 7/8</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5401 Cromwell Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clara</u>		4. DATE OF DEATH Nov. 2, 1958 19	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-82</u>
9. AGE (in years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC.</u>	
11. BIRTHPLACE (State or foreign country) <u>DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Bernheimer</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Henry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>578-48-0589</u>	
17. INFORMANT <u>Bernard H. Conn</u>		Address <u>Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>11/2/58</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WASH. HEBREW</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph G. Lewis Sons 1736 Penna. Ave.</u>		24a. REC'D BY REGISTRAR NOV 5 '58	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
COUNTY OF _____

STATE OF TEXAS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
EDUCATION		OCCUPATION		MARRIAGE		RELIGION		POLITICAL PARTY	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		HOURS OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION	
TIME OF EXAMINATION		TIME OF EXAMINATION		TIME OF EXAMINATION		TIME OF EXAMINATION		TIME OF EXAMINATION	
PLACE OF EXAMINATION		PLACE OF EXAMINATION		PLACE OF EXAMINATION		PLACE OF EXAMINATION		PLACE OF EXAMINATION	
CITY OF EXAMINATION		CITY OF EXAMINATION		CITY OF EXAMINATION		CITY OF EXAMINATION		CITY OF EXAMINATION	
STATE OF EXAMINATION		STATE OF EXAMINATION		STATE OF EXAMINATION		STATE OF EXAMINATION		STATE OF EXAMINATION	
COUNTRY OF EXAMINATION		COUNTRY OF EXAMINATION		COUNTRY OF EXAMINATION		COUNTRY OF EXAMINATION		COUNTRY OF EXAMINATION	
SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION	
TIME OF EXAMINATION		TIME OF EXAMINATION		TIME OF EXAMINATION		TIME OF EXAMINATION		TIME OF EXAMINATION	
PLACE OF EXAMINATION		PLACE OF EXAMINATION		PLACE OF EXAMINATION		PLACE OF EXAMINATION		PLACE OF EXAMINATION	
CITY OF EXAMINATION		CITY OF EXAMINATION		CITY OF EXAMINATION		CITY OF EXAMINATION		CITY OF EXAMINATION	
STATE OF EXAMINATION		STATE OF EXAMINATION		STATE OF EXAMINATION		STATE OF EXAMINATION		STATE OF EXAMINATION	
COUNTRY OF EXAMINATION		COUNTRY OF EXAMINATION		COUNTRY OF EXAMINATION		COUNTRY OF EXAMINATION		COUNTRY OF EXAMINATION	

12629

CERTIFICATE OF DEATH

12605

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>X</u> Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4700 West Virginia Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>C.</u> Last <u>Baxter</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/6/87</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>? Baxter</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs Lena Broadhurst-Item# 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>330x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Paralytic Ileus</u> DUE TO (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 Days</u> <u>48 hours</u> <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralytic Ileus</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 19, 1958</u> , to <u>Nov 30, 1958</u> , that I last saw the deceased alive on <u>Nov 30, 1958</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u> M.D.		ADDRESS (Street, city or town, state) <u>10511 Summit Ave</u> DATE SIGNED <u>12-1-58</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>		<u>Kensington, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12630

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 729 EASLEY STREET				d. STREET ADDRESS 1729 EASLEY STREET			
3. NAME OF DECEASED (Type or print) First VICTOR Middle HUGO Last BENDER				4. DATE OF DEATH Month NOV. Day 20 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/11/96	
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR - D.C. Property Yards		11. BIRTHPLACE (State or foreign country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RUDOLPH BENDER				14. MOTHER'S MAIDEN NAME IDA FISCHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Hallie G. Bender, 729 Easley St. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/22 19 53 , to 11/20 19 58 , that I last saw the deceased alive on 11/18 19 58 , and that death occurred at 3:10 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1150 Conn Ave. Wash. 6, D.C. DATE SIGNED 11/20/58							
ACTUAL SIGNATURE H. Luthers Hall		M.D. 1150 Conn Ave. Wash. 6, D.C.					
PHYSICIAN'S NAME (Type) W. Luther Hall							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/24/58		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey INC. Raymond A. Zaka				24a. REC'D BY REGISTRAR NOV 24 '58		24b. REGISTRAR'S SIGNATURE Arthur J. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

0250

12631

CERTIFICATE OF DEATH

12607

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>7600 Cayuga Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Daniel Dwyer</u> First <u>W. Blaylock</u> Middle Last				4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 10, 1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>15</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mining Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Blaylock</u>				14. MOTHER'S MAIDEN NAME <u>Meyers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>322-07-8239</u>			
17. INFORMANT <u>Wife</u> Address <u>Mary Blaylock - Same</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X Uremia</u> DUE TO <u>Chronic Glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>years</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Infarction Left Internal Capsule</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>NOV 4, 1958</u> to <u>NOV 25, 1958</u> , that I last saw the deceased alive on <u>11-25-58</u> , 1958, and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. Tilley, Jr.</u>				ADDRESS (Street, city or town, state) <u>4701 Mass. Ave. n.w.</u> DATE SIGNED <u>11-25-58</u>			
PHYSICIAN'S NAME (Type) <u>R. M. Tilley</u>				<u>Wash. 1670.</u>			
22a. BURIAL, CREMATION, REMOVAL, OR DISPOSITION <u>Burial Transit</u>		22b. DATE THEREOF <u>11/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Marissa</u>		22d. LOCATION (City, town, or county) (State) <u>Marissa, Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Bur-transit	11/13/58		Douglas, Arizona	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey,		Bethesda, Maryland	DATE 11/14/58	

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12633

CERTIFICATE OF DEATH

12609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>3 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2990 FORSYTHE AVENUE</u>		d. STREET ADDRESS <u>2990 FORSYTHE AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>KING</u> Last <u>BOISVERT</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 11-1876</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEACHING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARCELLUS Falls, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MARTIN KING</u>		14. MOTHER'S MAIDEN NAME <u>HENORA LYCON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS MARCELLUS WATSON</u>		Address <u>2990 FORSYTHE AVE SILVER SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>Nov 7</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Nov 7</u> , 19 <u>58</u> , and that death occurred at <u>9:40 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph F. Patten</u> M.D.		ADDRESS (Street, city or town, state) <u>8641 Coleridge Road Silver Spring, MD</u>	
DATE SIGNED <u>Nov 7, 58</u>			
PHYSICIAN'S NAME (Type) <u>RALPH F. PATTEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL 11-8-58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATOR <u>ST MARYS CEMETARY</u>		22d. LOCATION (City, town, or county) (State) <u>WATERLOO NEW YORK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS CO INC</u>		ADDRESS <u>1400 CHAPIN ST WASHINGTON DC</u>	
24a. REC'D BY REGISTRAR <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

15-103

Page 1 of 1

<p>1. Name of deceased: <u>JOHN J. WILSON</u></p>		<p>2. Date of death: <u>10-15-1918</u></p>	
<p>3. Place of death: <u>Home</u></p>		<p>4. Age: <u>65</u></p>	
<p>5. Sex: <u>Male</u></p>		<p>6. Race: <u>White</u></p>	
<p>7. Marital status: <u>Married</u></p>		<p>8. Occupation: <u>Engineer</u></p>	
<p>9. Cause of death: <u>Heart disease</u></p>		<p>10. Immediate cause: <u>Myocardial infarction</u></p>	
<p>11. Contributing causes: <u>None</u></p>		<p>12. Duration of illness: <u>2 weeks</u></p>	
<p>13. Name of physician: <u>Dr. J. H. Smith</u></p>		<p>14. Name of funeral home: <u>None</u></p>	
<p>15. Name of next of kin: <u>John J. Wilson</u></p>		<p>16. Address of next of kin: <u>123 Main St.</u></p>	
<p>17. Signature of physician: <u>[Signature]</u></p>		<p>18. Signature of registrar: <u>[Signature]</u></p>	
<p>19. Date of registration: <u>10-16-1918</u></p>		<p>20. Place of registration: <u>Baltimore</u></p>	

81 8 50 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

12634

CERTIFICATE OF DEATH

Reg. Dist. No.

12610

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>121 Martha's Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Beverley</u> Middle <u>Munford</u> Last <u>Bowie</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 5, 1914</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Journalism</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Walter R. Bowie</u>				14. MOTHER'S MAIDEN NAME <u>Jean Laverack</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>Unascertainable</u>			
17. INFORMANT <u>The Medical Record</u>				18. ADDRESS <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY INSUFFICIENCY</u> 228X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic tumor to lungs, bilat</u> DUE TO (c) <u>HEMANGIOPERICYTOMA AT CERVICAL SPINE</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS.</u> <u>1 YR.</u> <u>2 YRS.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SPINE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November 10, 1958</u> , to <u>November 15, 1958</u> , that I last saw the deceased alive on <u>November 15, 1958</u> , and that death occurred at <u>3:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold R. Silberman</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/15/58</u>			
PHYSICIAN'S NAME (Type) <u>HAROLD R. SILBERMAN, M.D.</u>				ADDRESS <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11-17-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Barry Mount</u>				ADDRESS <u>Cunningham Funeral Home Inc. Box 65 Alex., Va.</u>			
24a. REC'D BY REGISTRAR <u>NOV 18 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

12635

CERTIFICATE OF DEATH

12611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Bethesda</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5621 Greentree Road</u>				d. STREET ADDRESS <u>5621 Greentree Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>J. Reed Bradley</u>				4. DATE OF DEATH Month Day Year <u>November 16 19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 15, 1902</u>	
9. AGE (In years last birthday) <u>56</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sup. of Claims</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburg, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Herbert Bradley</u>				14. MOTHER'S MAIDEN NAME <u>Jane Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Gertrude D. Bradley-Item# 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Seminal Vesicles</u> <u>179.7</u> DUE TO <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4</u> , 19 <u>58</u> , to <u>11-16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-15</u> , 19 <u>58</u> , and that death occurred at <u>6:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1150 Conn Ave NW - Wash. DC</u> DATE SIGNED <u>11/16/58</u>							
ACTUAL SIGNATURE <u>Andrew G Prandoni</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Andrew G Prandoni</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 19 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12636

CERTIFICATE OF DEATH

Reg. Dist. No.

12612

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9513 GARWOOD STREET</u>			e. STREET ADDRESS <u>1 9513 GARWOOD STREET</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES HAROLD BRAMHALL</u>			4. DATE OF DEATH Month Day Year <u>NOV. 11 1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/12/1900</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICAL ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
13. FATHER'S NAME <u>CHARLES R. BRAMHALL</u>			14. MOTHER'S MAIDEN NAME <u>EMMA ALTENBURG</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES 1919-1922</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Mildred W. Bramhall, 9513 Garwood St. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> (c) <u>Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>9/1</u> , 19 <u>53</u> to <u>11/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/28</u> , 19 <u>58</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1150 Conn. Ave. Wash. 6, D.C. 11/12/58</u>					
ACTUAL SIGNATURE <u>W. Luther Hall</u>		M.D. <u>1150 Conn. Ave. Wash. 6, D.C. 11/12/58</u>			
PHYSICIAN'S NAME (Type) <u>W. LUTHER HALL</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL 11/15/58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Perryville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington County, Pa.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

12637

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home		d. STREET ADDRESS 111 Bishop Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OLIVE Middle Young Last BROOKSHIRE		4. DATE OF DEATH Month November Day 13 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Mike Young		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Small	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Donald Crawford-111 Bishop Lane		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, left cerebral artery DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive vascular disease DUE TO 7-year (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis, rt. side 3 years ago; 2nd stroke 1 year ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1/58 , to 11/13/58 , that I last saw the deceased alive on 10/1/58 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward W. Youngblood M.D.		ADDRESS (Street, city or town, state) 2248 Washington Ave., Silver Spring, Md.	
DATE SIGNED 11/13/58			
PHYSICIAN'S NAME (Type) EDWARD W. YOUNG-BLOOD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company-Washington, D.C.		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. HENRY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 1885	
5. PLACE OF BIRTH Boston, Mass.		6. OCCUPATION Clerk	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1910	
9. NAME OF SPOUSE Mary J. Henry		10. DATE OF DEATH 1920	
11. PLACE OF DEATH Boston, Mass.		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY None		14. SIGNATURE OF PHYSICIAN Dr. J. J. Smith	
15. SIGNATURE OF REGISTRAR John Doe		16. SIGNATURE OF WITNESSES John Doe, Mary Jane	
17. NAME OF FUNERAL HOME None		18. NAME OF BURIAL PLACE None	
19. NAME OF NEXT OF KIN None		20. NAME OF CEMETERY None	
21. NAME OF FUNERAL HOME None		22. NAME OF BURIAL PLACE None	
23. NAME OF NEXT OF KIN None		24. NAME OF CEMETERY None	
25. NAME OF FUNERAL HOME None		26. NAME OF BURIAL PLACE None	
27. NAME OF NEXT OF KIN None		28. NAME OF CEMETERY None	
29. NAME OF FUNERAL HOME None		30. NAME OF BURIAL PLACE None	
31. NAME OF NEXT OF KIN None		32. NAME OF CEMETERY None	
33. NAME OF FUNERAL HOME None		34. NAME OF BURIAL PLACE None	
35. NAME OF NEXT OF KIN None		36. NAME OF CEMETERY None	
37. NAME OF FUNERAL HOME None		38. NAME OF BURIAL PLACE None	
39. NAME OF NEXT OF KIN None		40. NAME OF CEMETERY None	
41. NAME OF FUNERAL HOME None		42. NAME OF BURIAL PLACE None	
43. NAME OF NEXT OF KIN None		44. NAME OF CEMETERY None	
45. NAME OF FUNERAL HOME None		46. NAME OF BURIAL PLACE None	
47. NAME OF NEXT OF KIN None		48. NAME OF CEMETERY None	
49. NAME OF FUNERAL HOME None		50. NAME OF BURIAL PLACE None	
51. NAME OF NEXT OF KIN None		52. NAME OF CEMETERY None	
53. NAME OF FUNERAL HOME None		54. NAME OF BURIAL PLACE None	
55. NAME OF NEXT OF KIN None		56. NAME OF CEMETERY None	
57. NAME OF FUNERAL HOME None		58. NAME OF BURIAL PLACE None	
59. NAME OF NEXT OF KIN None		60. NAME OF CEMETERY None	
61. NAME OF FUNERAL HOME None		62. NAME OF BURIAL PLACE None	
63. NAME OF NEXT OF KIN None		64. NAME OF CEMETERY None	
65. NAME OF FUNERAL HOME None		66. NAME OF BURIAL PLACE None	
67. NAME OF NEXT OF KIN None		68. NAME OF CEMETERY None	
69. NAME OF FUNERAL HOME None		70. NAME OF BURIAL PLACE None	
71. NAME OF NEXT OF KIN None		72. NAME OF CEMETERY None	
73. NAME OF FUNERAL HOME None		74. NAME OF BURIAL PLACE None	
75. NAME OF NEXT OF KIN None		76. NAME OF CEMETERY None	
77. NAME OF FUNERAL HOME None		78. NAME OF BURIAL PLACE None	
79. NAME OF NEXT OF KIN None		80. NAME OF CEMETERY None	
81. NAME OF FUNERAL HOME None		82. NAME OF BURIAL PLACE None	
83. NAME OF NEXT OF KIN None		84. NAME OF CEMETERY None	
85. NAME OF FUNERAL HOME None		86. NAME OF BURIAL PLACE None	
87. NAME OF NEXT OF KIN None		88. NAME OF CEMETERY None	
89. NAME OF FUNERAL HOME None		90. NAME OF BURIAL PLACE None	
91. NAME OF NEXT OF KIN None		92. NAME OF CEMETERY None	
93. NAME OF FUNERAL HOME None		94. NAME OF BURIAL PLACE None	
95. NAME OF NEXT OF KIN None		96. NAME OF CEMETERY None	
97. NAME OF FUNERAL HOME None		98. NAME OF BURIAL PLACE None	
99. NAME OF NEXT OF KIN None		100. NAME OF CEMETERY None	

12638

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>22 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10104 Lorain Ave</u>				d. STREET ADDRESS <u>10104 Lorain Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Nettie Isabel Hill Brougham</u>				4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAUC.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>27 October 1876</u>	
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min. <u>20</u>		IF UNDER 24 HRS. Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min. <u>20</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GENEALOGIST</u>			
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Sullivan D. Hill</u>				14. MOTHER'S MAIDEN NAME <u>Caroline M. Allen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>574-16-6773</u>			
17. INFORMANT <u>Allen Ross Brougham</u>				Address <u>Meadowhill Montkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>444x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1940</u> to <u>16 Nov</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 Nov</u> , 19 <u>58</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William D. Aud</u>				ADDRESS (Street, city or town, state) <u>9606 Colisville Rd Silver Spring, Md</u>			
DATE SIGNED <u>11/16/58</u>							
PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grace Episcopal Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond D. Zucka</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 19 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

1902

1. Name of deceased: *John William Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *October 15, 1902*

5. Place of death: *Home, 123 Main St., Baltimore, Md.*

6. Cause of death: *Heart disease*

7. Signature of physician: *John Doe, M.D.*

8. Signature of registrar: *John Doe*

9. Signature of informant: *John Doe*

10. Date of registration: *October 15, 1902*

11. Place of registration: *Baltimore, Md.*

12. Name of registrar: *John Doe*

13. Name of informant: *John Doe*

14. Name of physician: *John Doe, M.D.*

15. Name of funeral home: *John Doe*

16. Name of cemetery: *John Doe*

17. Name of burial place: *John Doe*

18. Name of burial place: *John Doe*

19. Name of burial place: *John Doe*

20. Name of burial place: *John Doe*

12639

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen. Hosp.				d. STREET ADDRESS 4513 Muncaster Mill Rd.	
3. NAME OF DECEASED (Type or print) First LOLA Middle PARKER Last BROWN			4. DATE OF DEATH Month NOVEMBER Day 5 Year 1958		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/73		9. AGE (In years last birthday) 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Kentucky	
13. FATHER'S NAME STILES O. PARKER			14. MOTHER'S MAIDEN NAME ALICE TILLER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Elizabeth Lawson, 6247 Lee Highway	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arlington, Virginia					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/6/58	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 11/8/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	
22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MD.		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE NOV 10 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12640

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8013 TAKOMA AVENUE		d. STREET ADDRESS 8013 TAKOMA AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle A. Last BROWN		4. DATE OF DEATH Month 11 Day 18 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/92
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN OTT		14. MOTHER'S MAIDEN NAME LOUISE SCHULER MD.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. S. M. DEFFINBAUGH		Address SILVER SPRING 8904 FLOWER AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Degeneration DUE TO (c) Generalized Arterio Sclerosis			INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 19, 1958 , to Nov 18, 1958 , that I last saw the deceased alive on Nov 14, 1958 , and that death occurred at 9 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Merrill M. Cross M.D.		ADDRESS (Street, city or town, state) 8248 G-CORP-1A AVE. BALTIMORE, MARYLAND.	
DATE SIGNED 11/18/58			
PHYSICIAN'S NAME (Type) MERRILL M. CROSS M.D.		SILVER SPRING, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/20/58	
22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM.		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS WASH. D.C. 41th. ST. N.W.	
24a. REC'D BY REGISTRAR NOV 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH-BALTIMORE 10

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

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12641

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN - 5600 Old Geo. Town Rd.</u>				d. STREET ADDRESS <u>4407 - Brookfield Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Bell</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 22 - 1909</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spec. Projects (clerical)</u>				11. BIRTHPLACE (State or foreign country) <u>NAVY Dept. U.S. Washington DC</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William CARROLL Bell</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Forest GIBSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-28-1808</u>		17. INFORMANT <u>Daughter</u> Address <u>Jeann Anthony - 10411 Ewell Ave. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MIDBRAIN compression</u> DUE TO <u>Cerebral edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Internal carotid thrombosis</u> (c) <u>11 days</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 9</u> , 19 <u>58</u> , to <u>Nov 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 14</u> , 19 <u>58</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John T. Lord</u>				DATE SIGNED <u>2025 Eye St. NW. WASH DC 11/14/58</u>			
PHYSICIAN'S NAME (Type) <u>John T. Lord MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 17 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18-21 Film 235 10-13-58

12642

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4814 Bradley Blvd Apt 21</u>		d. STREET ADDRESS <u>4814 Bradley Blvd Apt 21</u>	
3. NAME OF DECEASED (Type or print) <u>John Cristad Bryn</u>		4. DATE OF DEATH <u>Nov. 2 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-02</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V. Adm.</u>	
11. BIRTHPLACE (State or foreign country) <u>Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Helmer Bryn</u>		14. MOTHER'S MAIDEN NAME <u>Laura Cristad</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Eliz Bryn (wife)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration of stomach contents</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Apparently became ill and fell.</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in bath room of his home with head submerged in bath tub half filled with water. Neg. drowning for</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bethesda Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschaut</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschaut</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>11-2-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>SILVER SPRING MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawler's Sons</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kinne</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12643

CERTIFICATE OF DEATH

12619

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b X Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Sanitarium		d. STREET ADDRESS 3710 Underwood Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JULIA P. BURGESS		4. DATE OF DEATH Month Nov. Day 6 Year 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1872
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wm. P. Zollinger		14. MOTHER'S MAIDEN NAME Florence Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Newbold Burgess		Address 1650 Harvard Apts. Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE HEART DISEASE DUE TO (c) ESSENTIAL HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIO SCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 14, 1955 , to Nov. 6, 1958 , that I last saw the deceased alive on Nov. 6, 1958 , and that death occurred at 8:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5206 Norway Dr. Chevy Chase, Md. ACTUAL SIGNATURE Henry M. Howden M.D. PHYSICIAN'S NAME (Type) HENRY M. HOWDEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1958	
22c. NAME OF CEMETERY OR CREMATORY Lorraine		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place		24a. REC'D BY REGISTRAR DATE Nov 10 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12620

12644

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Rhode Island b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 6 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lebeau Gardens Nursing Home				d. STREET ADDRESS 156 Medway Street			
3. NAME OF DECEASED (Type or print) Herbert Stevenson Busey				4. DATE OF DEATH November 20 Day 20 Year 58			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 21, 1879	
9. AGE (In years and birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Designer (ret.)				10b. KIND OF BUSINESS OR INDUSTRY Machine		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William McClanahan Busey				14. MOTHER'S MAIDEN NAME Mary Emelia Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 035 07 3927		17. INFORMANT Mrs. Mary B. Fay, Takoma Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperpyrexia 715X DUE TO Septicemia, Probably Staphylococcal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Decubitus ulcers, Buttocks, Old (c)				INTERVAL BETWEEN ONSET AND DEATH 24 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 4 , 19 57 to Nov 20 , 19 58 , that I last saw the deceased alive on Nov 20 , 19 58 , and that death occurred at 4:45 p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert T. Thibadeau M.D.				ADDRESS (Street, city or town, state) 10609 Concord St.			
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D. Kensington, Md.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 22, 1958		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters				ADDRESS 254 Carroll at NW 1st		24a. REC'D BY REGISTRAR NOV 24 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Pineda			

may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12645

CERTIFICATE OF DEATH

12621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Rhode Island b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Julia Bridener Busey				4. DATE OF DEATH Month November Day 15 Year 58			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 26, 1877	
9. AGE (In years last birthday) 81 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Maurice Bridener		14. MOTHER'S MAIDEN NAME Julia A. Curley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary B. Fay		Address Interden Park, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Old Cerebral Thrombosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 30 MIN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) MD		(State) Md	
21. I certify that I attended the deceased from Nov 1 , 19 58 to Nov 15 , 19 58 , that I last saw the deceased alive on Nov 13 , 19 58 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert T. Thibadeau		M.D. Robert T. Thibadeau, M.D.		ADDRESS (Street, city or town, state) 10609 Concord St. Kensington, Maryland		DATE SIGNED Nov 19 58	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau		22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Nov 18, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
22d. LOCATION (City, town, or county) Baltimore		(State) Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Agathe Walker		24a. REC'D BY REGISTRAR Nov 19 58	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns		25. ADDRESS 254 Carroll St. D.C.		26. DATE Nov 19 58		27. SIGNATURE Arthur S. Huns	

12599

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York City</u> 69X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>434 W. 20th ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Mackenzie Byrne</u>				4. DATE OF DEATH Month Day Year <u>11 - 7 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-9-22</u>	
9. AGE (In years last birthday) <u>36</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>America</u>	
13. FATHER'S NAME <u>Daniel J. Byrne</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mackenzie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accidents</u>							
331X DUE TO: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anemia - Severe</u>							
DUE TO: (c) <u>Circulatory Shock</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-6-58</u> , 19 <u>58</u> , to <u>11-7-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-6-58</u> , 19 <u>58</u> , and that death occurred at <u>32 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph H. Clapp</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave Takoma Park Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. Arthur Walters</u>				DATE SIGNED <u>Nov 13 '58</u>			
22a. BURIAL, CREMATION, REBURY (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 8, 1958</u>		<u>Rock Creek Cemetery</u>		<u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				24. REC'D BY REGISTRAR <u>Arthur L. Knaus</u>			
ADDRESS <u>254 Carroll St NW DC</u>				DATE <u>Nov 13 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12646 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN 1b 8 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 905 GIST AVENUE		d. STREET ADDRESS 905 GIST AVENUE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ELIZABETH Dillon CALLAHAN		4. DATE OF DEATH Month NOV. Day 24 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 31, 1879
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Dillon	
14. MOTHER'S MAIDEN NAME Joanna Gallagher		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Joseph LeClair, 905 Gist Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/26/58	
22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond W. Giska		24a. REC'D BY REGISTRAR DATE NOV 26 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

2

12647

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>30 minutes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SILVER SPRING SUBURBAN HOSP. BETHESDA, MD.</u>				e. STREET ADDRESS <u>2819 IVYDALE STREET</u>			
3. NAME OF DECEASED (Type or print) <u>PHILIP ANTHONY CAMARANO</u>				4. DATE OF DEATH <u>NOVEMBER 27 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 12, 1953</u>	
9. AGE (In years lost birthday) <u>5</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		11. BIRTHPLACE (State or foreign country) <u>LANSING, MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ANTHONY MICHAEL CAMARANO</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA CATHERINE RINEHART</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mr. Anthony M. Camarano</u> Address <u>2819 IVYDALE ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>474X CARDIAC ARREST</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE TRACHEO LARYNGITIS, SEVERE</u> DUE TO (c) <u>E LARYNGEAL EDEMA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>November 26, 1958</u> , to <u>November 27, 1958</u> , that I last saw the deceased alive on <u>November 27, 1958</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Belden R. Reap</u>				ADDRESS (Street, city or town, state) <u>11502 GRANDVIEW AVE. SILVER SPRING, MD.</u>			
PHYSICIAN'S NAME (Type) <u>BELDEN R. REAP</u>				DATE SIGNED <u>Nov. 27, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC. Raymond A. Buska</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Moore</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12648

CERTIFICATE OF DEATH

12625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>21 days</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XWheaton</u> d. STREET ADDRESS <u>2318 Blueridge Ave., Apt. 105</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alyce Brooks Campbell</u>			4. DATE OF DEATH Month Day Year <u>November 26, 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 19, 1916</u>	9. AGE (In years lost birthday) <u>42 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unascertainable</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
13. FATHER'S NAME <u>Walter A. Hall</u>			14. MOTHER'S MAIDEN NAME <u>Myrtle Walker</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>461-09-7199</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bilateral Ureteral Obstruction</u> DUE TO (c) <u>Carcinoma of Cervix</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 5, 1958</u> to <u>November 26, 1958</u> , that I last saw the deceased alive on <u>November 26, 1958</u> , and that death occurred at <u>6:16 P</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>John S. Dillon</u>		M.D. <u>The Clinical Center</u> <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u>		ADDRESS (Street, city or town, state) <u>11-27-58</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>John S. Dillon, M. D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>11/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 1 58</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. P. P.</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
MAYNARD		MALE		35		11/28/55	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Ft. Worth, Texas		Salesman		Myocardial Infarction		Natural	
Physician		Burial		Place of Burial		Date of Burial	
Dr. J. H. Smith		St. Mary's Cemetery		St. Mary's Cemetery		12/5/55	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]	

Robert A. Humphrey-Hethcote, Maryland
Surrogate 11/28/55
Ft. Worth, Texas

12600

CERTIFICATE OF DEATH

12626

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>25 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Irene</u> Last <u>Canter</u>				4. DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-2-82</u>	
9. AGE (In years lost birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William B. Perry</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Ferguson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Coronary artery thrombosis with myocardial infarction</u> DUE TO (b) <u>Diabetes mellitus.</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerotic cardiovascular disease.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>11</u> Day <u>19</u> Year <u>1958</u> Hour o. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1958</u> , to <u>5 Nov 1958</u> , that I last saw the deceased alive on <u>5 Nov 1958</u> , and that death occurred at <u>4:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest Harmon</u>				ADDRESS (Street, city or town, state) <u>M.D. Silver Spring, Md.</u>		DATE SIGNED <u>11/5/58</u>	
PHYSICIAN'S NAME (Type) <u>Ernest Harmon, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Kraus</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12649

CERTIFICATE OF DEATH

12627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN 1b approx 5 yrs.		d. STREET ADDRESS 807 STERLING ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 807 STERLING ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last ELLA AMELIA CARMAN		4. DATE OF DEATH Month Day Year nov 18 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/23/68
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT B. MINAR		14. MOTHER'S MAIDEN NAME HELEN A. ANDREWS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address Mrs. Louis F. Miller, 807 Sterling Rd. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154x Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of rectum DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio-sclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 6 mo. 1 1/2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/15 19 38 to 11/18 19 58, that I last saw the deceased alive on nov 17 19 58, and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Chas W Harnsberger M.D. 4201 New Hamp ave NW PHYSICIAN'S NAME (Type) CHAS. W. HARNSEBERGER Washington DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/23/58	
22c. NAME OF CEMETERY OR CREMATORY SARANAC CEMETERY		22d. LOCATION (City, town, or county) (State) SARANAC, MICHIGAN	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WARNER E. PUMPHREY, INC. SILVER SPRING, MD. Raymond E. Zicka		24a. REC'D BY REGISTRAR DATE NOV 20 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12650

CERTIFICATE OF DEATH

12628

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 52 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegheny	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 439 Williams Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Charles Frank Carnell		4. DATE OF DEATH Month Day Year November 8 1958							
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 1, 1894	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Carnell		14. MOTHER'S MAIDEN NAME Sarah E. Robinson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 705 07 9705		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung & metastasis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 17, 1958 , to November 8, 1958 , that I last saw the deceased alive on November 8, 1958 , and that death occurred at 12:40 A.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE James M. Marsh		M.D. The Clinical Center		DATE SIGNED 11-8-58					
PHYSICIAN'S NAME (Type) James M. Marsh, M.D.		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR NOV 10 58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12651

CERTIFICATE OF DEATH

Reg. Dist. No.

12629

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS GAITHERSBURG, MD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANNIE Middle CEPHAS Last CEPHAS				4. DATE OF DEATH Month 11/ Day 4/ Year 19 58			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1875	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL FISHER				14. MOTHER'S MAIDEN NAME HARRIETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Hester M. Dorsey Address Gaithersburg, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 10, 1952 to Nov 4, 1958 , that I last saw the deceased alive on Nov 1, 1958 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Keras M.D.				ADDRESS (Street, city or town, State) Homewood, Md.		DATE SIGNED 11/6/58	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/7/58		22c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cemetery		22d. LOCATION (City, town, or county) (State) Laytonsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Shander				24a. REC'D BY REGISTRAR DATE NOV 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF CALIFORNIA - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. PLACE OF BIRTH [REDACTED]</p>	
<p>10. OCCUPATION [REDACTED]</p>		<p>11. MARITAL STATUS [REDACTED]</p>		<p>12. EDUCATION [REDACTED]</p>	
<p>13. PREVIOUS ILLNESS [REDACTED]</p>		<p>14. PREVIOUS SURGERY [REDACTED]</p>		<p>15. PREVIOUS TRAUMA [REDACTED]</p>	
<p>16. PREVIOUS DRUGS [REDACTED]</p>		<p>17. PREVIOUS ALCOHOL [REDACTED]</p>		<p>18. PREVIOUS TOBACCO [REDACTED]</p>	
<p>19. PREVIOUS RADIATION [REDACTED]</p>		<p>20. PREVIOUS CHEMOTHERAPY [REDACTED]</p>		<p>21. PREVIOUS TRANSFUSION [REDACTED]</p>	
<p>22. PREVIOUS ORGANS [REDACTED]</p>		<p>23. PREVIOUS TISSUES [REDACTED]</p>		<p>24. PREVIOUS CELLS [REDACTED]</p>	
<p>25. PREVIOUS MOLECULES [REDACTED]</p>		<p>26. PREVIOUS ATOMS [REDACTED]</p>		<p>27. PREVIOUS PARTICLES [REDACTED]</p>	
<p>28. PREVIOUS WAVES [REDACTED]</p>		<p>29. PREVIOUS FIELDS [REDACTED]</p>		<p>30. PREVIOUS FORCES [REDACTED]</p>	
<p>31. PREVIOUS ENERGY [REDACTED]</p>		<p>32. PREVIOUS MATTER [REDACTED]</p>		<p>33. PREVIOUS SPACE [REDACTED]</p>	
<p>34. PREVIOUS TIME [REDACTED]</p>		<p>35. PREVIOUS MOTION [REDACTED]</p>		<p>36. PREVIOUS CHANGE [REDACTED]</p>	
<p>37. PREVIOUS CAUSE [REDACTED]</p>		<p>38. PREVIOUS EFFECT [REDACTED]</p>		<p>39. PREVIOUS RESULT [REDACTED]</p>	
<p>40. PREVIOUS ACTION [REDACTED]</p>		<p>41. PREVIOUS REACTION [REDACTED]</p>		<p>42. PREVIOUS RESPONSE [REDACTED]</p>	
<p>43. PREVIOUS BEHAVIOR [REDACTED]</p>		<p>44. PREVIOUS PERFORMANCE [REDACTED]</p>		<p>45. PREVIOUS FUNCTION [REDACTED]</p>	
<p>46. PREVIOUS ACTIVITY [REDACTED]</p>		<p>47. PREVIOUS OPERATION [REDACTED]</p>		<p>48. PREVIOUS PROCEDURE [REDACTED]</p>	
<p>49. PREVIOUS METHOD [REDACTED]</p>		<p>50. PREVIOUS TECHNIQUE [REDACTED]</p>		<p>51. PREVIOUS APPROACH [REDACTED]</p>	
<p>52. PREVIOUS STRATEGY [REDACTED]</p>		<p>53. PREVIOUS TACTIC [REDACTED]</p>		<p>54. PREVIOUS POLICY [REDACTED]</p>	
<p>55. PREVIOUS PROGRAM [REDACTED]</p>		<p>56. PREVIOUS PLAN [REDACTED]</p>		<p>57. PREVIOUS SCHEME [REDACTED]</p>	
<p>58. PREVIOUS DESIGN [REDACTED]</p>		<p>59. PREVIOUS PATTERN [REDACTED]</p>		<p>60. PREVIOUS FORM [REDACTED]</p>	
<p>61. PREVIOUS SHAPE [REDACTED]</p>		<p>62. PREVIOUS SIZE [REDACTED]</p>		<p>63. PREVIOUS COLOR [REDACTED]</p>	
<p>64. PREVIOUS TEXTURE [REDACTED]</p>		<p>65. PREVIOUS SOUND [REDACTED]</p>		<p>66. PREVIOUS TASTE [REDACTED]</p>	
<p>67. PREVIOUS SMELL [REDACTED]</p>		<p>68. PREVIOUS FEEL [REDACTED]</p>		<p>69. PREVIOUS TASTE [REDACTED]</p>	
<p>70. PREVIOUS TASTE [REDACTED]</p>		<p>71. PREVIOUS TASTE [REDACTED]</p>		<p>72. PREVIOUS TASTE [REDACTED]</p>	

10. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
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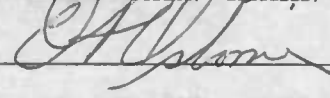
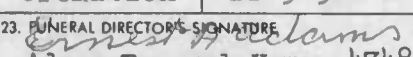
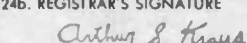
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12652

CERTIFICATE OF DEATH

12630

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 21 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 15 b. COUNTY Taiwan c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laoshium			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Navy Base		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Shao Middle Hua Last CHANG			4. DATE OF DEATH Month November Day 29 Year 19 58				
5. SEX Male		6. COLOR OR RACE Mongolian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-22-15	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 43		IF UNDER 24 HRS. Days 43		Hours 43	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armed Forces				10b. KIND OF BUSINESS OR INDUSTRY Chinese Marine Corps		11. BIRTHPLACE (State or foreign country) China	
12. CITIZEN OF WHAT COUNTRY? China							
13. FATHER'S NAME Shaohua Yutien CHANG				14. MOTHER'S MAIDEN NAME Wenchen WANG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - -		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatocarcinoma with metastasis 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 3 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from November 8, 19 58 , to November 29, 19 58 , that I last saw the deceased alive on November 28, 19 58 , and that death occurred at 4:35A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE 				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNM			
DATE SIGNED 12-1-58							
PHYSICIAN'S NAME (Type) D. P. OSBORNE, CAPT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 12-5-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) _____ (State) _____ Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE  ADDRESS Adams Funeral Home, 4748 Wisc. Ave., NW, Wash, DC				24a. REC'D BY REGISTRAR DATE DEC 4 '58		24b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STANDARD STATEMENT OF HEALTH-BATHING, 18

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12601 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12631

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7511 Carroll Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rene Guide Chatel</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 25, 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if kind was <u>trucking man</u>)		10b. KIND OF BUSINESS OR INDUSTRY <u>apt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Yonkers, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>LEWIS P. CHATEL</u>		14. MOTHER'S MAIDEN NAME <u>Clematis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>579-12-3668</u>	
17. INFORMANT <u>Mrs Lucille M. Chatel</u>		Address <u>1100 F. N. E. Wash DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>DECEMBER 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL CEM</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON ARLCO. VA</u>	
23. JUDICIAL DIRECTOR'S SIGNATURE <u>Arthur S. Pruss</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Pruss</u>			

MEDICAL CERTIFICATION

MASSACHUSETTS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13801

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. CAUSE OF DEATH: _____

8. MANNER OF DEATH: _____

9. SIGNATURE OF MEDICAL EXAMINER: _____

10. DATE OF EXAMINATION: _____

11. PLACE OF EXAMINATION: _____

12. SIGNATURE OF REGISTRAR: _____

13. DATE OF REGISTRATION: _____

14. PLACE OF REGISTRATION: _____

15. SIGNATURE OF CLERK: _____

16. DATE OF CLERKING: _____

17. PLACE OF CLERKING: _____

18. SIGNATURE OF JURY: _____

19. DATE OF JURY: _____

20. PLACE OF JURY: _____

21. SIGNATURE OF JUDGE: _____

22. DATE OF JUDGMENT: _____

23. PLACE OF JUDGMENT: _____

24. SIGNATURE OF SHERIFF: _____

25. DATE OF SHERIFF: _____

26. PLACE OF SHERIFF: _____

27. SIGNATURE OF CORONER: _____

28. DATE OF CORONER: _____

29. PLACE OF CORONER: _____

30. SIGNATURE OF JURY: _____

31. DATE OF JURY: _____

32. PLACE OF JURY: _____

33. SIGNATURE OF JUDGE: _____

34. DATE OF JUDGMENT: _____

35. PLACE OF JUDGMENT: _____

36. SIGNATURE OF SHERIFF: _____

37. DATE OF SHERIFF: _____

38. PLACE OF SHERIFF: _____

39. SIGNATURE OF CORONER: _____

40. DATE OF CORONER: _____

41. PLACE OF CORONER: _____

42. SIGNATURE OF JURY: _____

43. DATE OF JURY: _____

44. PLACE OF JURY: _____

45. SIGNATURE OF JUDGE: _____

46. DATE OF JUDGMENT: _____

47. PLACE OF JUDGMENT: _____

48. SIGNATURE OF SHERIFF: _____

49. DATE OF SHERIFF: _____

50. PLACE OF SHERIFF: _____

51. SIGNATURE OF CORONER: _____

52. DATE OF CORONER: _____

53. PLACE OF CORONER: _____

54. SIGNATURE OF JURY: _____

55. DATE OF JURY: _____

56. PLACE OF JURY: _____

57. SIGNATURE OF JUDGE: _____

58. DATE OF JUDGMENT: _____

59. PLACE OF JUDGMENT: _____

60. SIGNATURE OF SHERIFF: _____

61. DATE OF SHERIFF: _____

62. PLACE OF SHERIFF: _____

63. SIGNATURE OF CORONER: _____

64. DATE OF CORONER: _____

65. PLACE OF CORONER: _____

66. SIGNATURE OF JURY: _____

67. DATE OF JURY: _____

68. PLACE OF JURY: _____

69. SIGNATURE OF JUDGE: _____

70. DATE OF JUDGMENT: _____

71. PLACE OF JUDGMENT: _____

72. SIGNATURE OF SHERIFF: _____

73. DATE OF SHERIFF: _____

74. PLACE OF SHERIFF: _____

75. SIGNATURE OF CORONER: _____

76. DATE OF CORONER: _____

77. PLACE OF CORONER: _____

78. SIGNATURE OF JURY: _____

79. DATE OF JURY: _____

80. PLACE OF JURY: _____

81. SIGNATURE OF JUDGE: _____

82. DATE OF JUDGMENT: _____

83. PLACE OF JUDGMENT: _____

84. SIGNATURE OF SHERIFF: _____

85. DATE OF SHERIFF: _____

86. PLACE OF SHERIFF: _____

87. SIGNATURE OF CORONER: _____

88. DATE OF CORONER: _____

89. PLACE OF CORONER: _____

90. SIGNATURE OF JURY: _____

91. DATE OF JURY: _____

92. PLACE OF JURY: _____

93. SIGNATURE OF JUDGE: _____

94. DATE OF JUDGMENT: _____

95. PLACE OF JUDGMENT: _____

96. SIGNATURE OF SHERIFF: _____

97. DATE OF SHERIFF: _____

98. PLACE OF SHERIFF: _____

99. SIGNATURE OF CORONER: _____

100. DATE OF CORONER: _____

101. PLACE OF CORONER: _____

102. SIGNATURE OF JURY: _____

103. DATE OF JURY: _____

104. PLACE OF JURY: _____

105. SIGNATURE OF JUDGE: _____

106. DATE OF JUDGMENT: _____

107. PLACE OF JUDGMENT: _____

108. SIGNATURE OF SHERIFF: _____

109. DATE OF SHERIFF: _____

110. PLACE OF SHERIFF: _____

111. SIGNATURE OF CORONER: _____

112. DATE OF CORONER: _____

113. PLACE OF CORONER: _____

114. SIGNATURE OF JURY: _____

115. DATE OF JURY: _____

116. PLACE OF JURY: _____

117. SIGNATURE OF JUDGE: _____

118. DATE OF JUDGMENT: _____

119. PLACE OF JUDGMENT: _____

120. SIGNATURE OF SHERIFF: _____

121. DATE OF SHERIFF: _____

122. PLACE OF SHERIFF: _____

123. SIGNATURE OF CORONER: _____

124. DATE OF CORONER: _____

125. PLACE OF CORONER: _____

126. SIGNATURE OF JURY: _____

127. DATE OF JURY: _____

128. PLACE OF JURY: _____

129. SIGNATURE OF JUDGE: _____

130. DATE OF JUDGMENT: _____

131. PLACE OF JUDGMENT: _____

132. SIGNATURE OF SHERIFF: _____

133. DATE OF SHERIFF: _____

134. PLACE OF SHERIFF: _____

135. SIGNATURE OF CORONER: _____

136. DATE OF CORONER: _____

137. PLACE OF CORONER: _____

138. SIGNATURE OF JURY: _____

139. DATE OF JURY: _____

140. PLACE OF JURY: _____

141. SIGNATURE OF JUDGE: _____

142. DATE OF JUDGMENT: _____

143. PLACE OF JUDGMENT: _____

144. SIGNATURE OF SHERIFF: _____

145. DATE OF SHERIFF: _____

146. PLACE OF SHERIFF: _____

147. SIGNATURE OF CORONER: _____

148. DATE OF CORONER: _____

149. PLACE OF CORONER: _____

150. SIGNATURE OF JURY: _____

151. DATE OF JURY: _____

152. PLACE OF JURY: _____

153. SIGNATURE OF JUDGE: _____

154. DATE OF JUDGMENT: _____

155. PLACE OF JUDGMENT: _____

156. SIGNATURE OF SHERIFF: _____

157. DATE OF SHERIFF: _____

158. PLACE OF SHERIFF: _____

159. SIGNATURE OF CORONER: _____

160. DATE OF CORONER: _____

161. PLACE OF CORONER: _____

162. SIGNATURE OF JURY: _____

163. DATE OF JURY: _____

164. PLACE OF JURY: _____

165. SIGNATURE OF JUDGE: _____

166. DATE OF JUDGMENT: _____

167. PLACE OF JUDGMENT: _____

168. SIGNATURE OF SHERIFF: _____

169. DATE OF SHERIFF: _____

170. PLACE OF SHERIFF: _____

171. SIGNATURE OF CORONER: _____

172. DATE OF CORONER: _____

173. PLACE OF CORONER: _____

174. SIGNATURE OF JURY: _____

175. DATE OF JURY: _____

176. PLACE OF JURY: _____

177. SIGNATURE OF JUDGE: _____

178. DATE OF JUDGMENT: _____

179. PLACE OF JUDGMENT: _____

180. SIGNATURE OF SHERIFF: _____

181. DATE OF SHERIFF: _____

182. PLACE OF SHERIFF: _____

183. SIGNATURE OF CORONER: _____

184. DATE OF CORONER: _____

185. PLACE OF CORONER: _____

186. SIGNATURE OF JURY: _____

187. DATE OF JURY: _____

188. PLACE OF JURY: _____

189. SIGNATURE OF JUDGE: _____

190. DATE OF JUDGMENT: _____

191. PLACE OF JUDGMENT: _____

192. SIGNATURE OF SHERIFF: _____

193. DATE OF SHERIFF: _____

194. PLACE OF SHERIFF: _____

195. SIGNATURE OF CORONER: _____

196. DATE OF CORONER: _____

197. PLACE OF CORONER: _____

198. SIGNATURE OF JURY: _____

199. DATE OF JURY: _____

200. PLACE OF JURY: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12653

CERTIFICATE OF DEATH

12632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 32 Eastmore Drive		d. STREET ADDRESS 132 Eastmore Dr	
3. NAME OF DECEASED (Type or print) First M. Middle GRACE Last CIANGU		4. DATE OF DEATH Month NOV. Day 30 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dominic De Lorenzo		14. MOTHER'S MAIDEN NAME Josephine Riccardi	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Peter J. Ciango	
17. INFORMANT Peter J. Ciango		Address 3134 24th St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 24, 1958 , to Nov 30, 1958 that I last saw the deceased alive on Nov 30, 1958 , and that death occurred at 10:24 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Almaguer		ADDRESS (Street, city or town, state) 1746 R St NW	
PHYSICIAN'S NAME (Type) Almaguer		DATE SIGNED Dec 1 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-3-58	
22c. NAME OF CEMETERY OR CREMATORY St. Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Real Funeral Home		ADDRESS 4812 Ina Ave	
24a. REC'D BY REGISTRAR DEC 4 58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

ALBANY BOND

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of official	
13. Signature of official		14. Signature of official		15. Signature of official		16. Signature of official	
17. Signature of official		18. Signature of official		19. Signature of official		20. Signature of official	
21. Signature of official		22. Signature of official		23. Signature of official		24. Signature of official	
25. Signature of official		26. Signature of official		27. Signature of official		28. Signature of official	
29. Signature of official		30. Signature of official		31. Signature of official		32. Signature of official	
33. Signature of official		34. Signature of official		35. Signature of official		36. Signature of official	
37. Signature of official		38. Signature of official		39. Signature of official		40. Signature of official	
41. Signature of official		42. Signature of official		43. Signature of official		44. Signature of official	
45. Signature of official		46. Signature of official		47. Signature of official		48. Signature of official	
49. Signature of official		50. Signature of official		51. Signature of official		52. Signature of official	
53. Signature of official		54. Signature of official		55. Signature of official		56. Signature of official	
57. Signature of official		58. Signature of official		59. Signature of official		60. Signature of official	
61. Signature of official		62. Signature of official		63. Signature of official		64. Signature of official	
65. Signature of official		66. Signature of official		67. Signature of official		68. Signature of official	
69. Signature of official		70. Signature of official		71. Signature of official		72. Signature of official	
73. Signature of official		74. Signature of official		75. Signature of official		76. Signature of official	
77. Signature of official		78. Signature of official		79. Signature of official		80. Signature of official	
81. Signature of official		82. Signature of official		83. Signature of official		84. Signature of official	
85. Signature of official		86. Signature of official		87. Signature of official		88. Signature of official	
89. Signature of official		90. Signature of official		91. Signature of official		92. Signature of official	
93. Signature of official		94. Signature of official		95. Signature of official		96. Signature of official	
97. Signature of official		98. Signature of official		99. Signature of official		100. Signature of official	

12654

CERTIFICATE OF DEATH

12633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
c. LENGTH OF STAY IN 1b 8 days				d. STREET ADDRESS Route 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle C. Last Claggett				4. DATE OF DEATH Month November Day 7 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/17/00		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor foreman		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles C. Claggett				14. MOTHER'S MAIDEN NAME Cora Allison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> W.W. I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Lola A. Claggett		Address Route 2 Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis Right Ventricle							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-30 , 19 58 , to 11-7 , 19 58 , that I last saw the deceased alive on 11-6 , 19 58 , and that death occurred at 5:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Herman Maganzini				ADDRESS (Street, city or town, state) 809 Viers Mill Rd. Rockville, Md.			
PHYSICIAN'S NAME (Type) Herman Maganzini				DATE SIGNED 11/7/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/58		22c. NAME OF CEMETERY OR CREMATORY St. Marys		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE NOV 10 58		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

542

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12655 CERTIFICATE OF DEATH

12634

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>CLEMENTS</u> Last <u>8</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>26</u> Year <u>1958</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 21, 1909</u>		9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed Washington D.C.</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Thomas E. Clements</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>579-22-5651</u>				17. INFORMANT <u>Miss Irene Clement-Burtonsville</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Carcinoma Stomach</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>18 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Chronic Gastritis</u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/2</u> , 19 <u>58</u> , to <u>11/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/25</u> , 19 <u>58</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED															
ACTUAL SIGNATURE <u>J M Warren</u> M.D.				PHYSICIAN'S NAME (Type) <u>J M WARREN</u>											
22a. BURIAL, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/28/58</u>				22c. NAME OF CEMETERY OR CREMATORY <u>St Mary Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Laurel Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. McCallister</u>						ADDRESS <u>Laurel Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12635

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 5 hours		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY PH c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt d. STREET ADDRESS 2H Laurel Hill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Wallace Alexander CLUBB		4. DATE OF DEATH Month Day Year November 15 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-97
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY U.S.Govt.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. CLUBB		14. MOTHER'S MAIDEN NAME Anna L. NOTHEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 577-20-4772	
17. INFORMANT (S) Wallace A. Clubb, Jr., same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO (c) Electrolyte imbalance & uremia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 14, 19 58 , to November 15, 19 58 , that I last saw the deceased alive on November 15, 19 58 , and that death occurred at 12:20A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE F. H. O'Connell		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC	
DATE SIGNED 11-15-58		DATE	
PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LT, MC, USN		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, 4th & Mass.Ave., NW, Wash.D.C.		24a. REC'D BY REGISTRAR NOV 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BIRMINGHAM

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12057
CERTIFICATE OF DEATH

12636

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 2540 Southern Ave., S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Enrique Ricardo COBBS				4. DATE OF DEATH Month Day Year November 3 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-58		9. AGE (In years last birthday) yrs. 47	IF UNDER 1 YEAR Months Days Hours Min. 2	IF UNDER 24 HRS. Hours Min. 47
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sylvester E. COBBS				14. MOTHER'S MAIDEN NAME Ursula YEARWOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (F) Sylvester E. Cobbs, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Primary Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronicity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 47 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 1, 1958 , to November 3, 1958 , that I last saw the deceased alive on November 3, 1958 , and that death occurred at 5:45A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David Harris				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC		DATE SIGNED 11-3-58	
PHYSICIAN'S NAME (Type) David HARRIS, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.H. Bacon Funeral Home, 1722-7th St., NW, Washington, D.C.				24a. REC'D BY REGISTRAR NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Journal of the American Statistical Association

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12602
CERTIFICATE OF DEATH

12637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, c. LENGTH OF STAY IN 1b 56 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, d. STREET ADDRESS 10020 Reddick Drive, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cochran		4. DATE OF DEATH Month Day Year November 29, 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 29, 58
9. AGE (In years last birthday) yrs. 9 Min. 19		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Winston Earl Cochran		14. MOTHER'S MAIDEN NAME Gloria Lee Grimes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. husband	
17. INFORMANT same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/29, 1958 to 11/30, 1958 , that I last saw the deceased alive on 11/30, 1958 , and that death occurred at 139 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 925 Pershing Dr., Silver Spring, Md.			
ACTUAL SIGNATURE Raymond F. Chinn		M.D. 925 Pershing Dr., Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Raymond F. Chinn, M. D.		925 Pershing Dr., Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11-29-58	
22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital		22d. LOCATION (City, town, or county) (State) Takoma Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D.		ADDRESS Washington Sanitarium and Hospital	
24a. REC'D BY REGISTRAR DATE 12/1/58		24b. REGISTRAR'S SIGNATURE L. H. Hare	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12658 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12638

Reg. Dist. No.

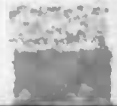
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 1001 Kathryn Road	
3. NAME OF DECEASED (Type or print) First Dudley Middle Harry Last COLEMAN		4. DATE OF DEATH Month November Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 December 1913
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired TEL USN		10b. KIND OF BUSINESS OR INDUSTRY South Carolina	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Leslie COLEMAN		14. MOTHER'S MAIDEN NAME Bessie Virginia FOUNTIAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 577 16 7157	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 7 November 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Pumphrey Funeral Home, 8434 Ga. Ave.,		24. REGISTRAR'S SIGNATURE Arthur S. Knaus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1922 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STANDARD STATE CERTIFICATE OF DEATH-BALTIMORE 15

Name of Deceased		John Doe	
Sex		Male	
Age		45	
Date of Death		October 15, 1922	
Place of Death		Home	
Cause of Death		Heart Disease	
Disease or Injury		Coronary Arteriosclerosis	
Occupation		Teacher	
Residence		123 Main St., Houston, Texas	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Physician		[Signature]	
Signature of Nurse		[Signature]	
Signature of Family		[Signature]	
Signature of Witness		[Signature]	
Signature of Minister		[Signature]	
Signature of Priest		[Signature]	
Signature of Rabbi		[Signature]	
Signature of Imam		[Signature]	
Signature of Other		[Signature]	



12659

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 232 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS Route 1, Box 402B		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Collins			4. DATE OF DEATH Month November Day 13 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1912		9. AGE (In years last birthday) 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Jerry Ward			14. MOTHER'S MAIDEN NAME Esther Tuller		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 429-34-3594		17. INFORMANT The Medical Record address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Right Kidney 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from March 26, 1958 , to November 13, 1958 , that I last saw the deceased alive on November 13, 1958 , and that death occurred at 11:00 AM , from the causes and on the date stated above					
ACTUAL SIGNATURE G. Richard Lee		M.D. The Clinical Center		DATE SIGNED 11-13-58	
PHYSICIAN'S NAME (Type) G. Richard Lee, M.D.		National Institutes of Health		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 11/15/58		22b. DATE THEREOF 11/15/58		22c. NAME OF CEMETERY OR CREMATORY Worthington	
22d. LOCATION (City, town, or county) Ohio		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR Nov 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased		Sex		Age	
John Doe		Male		45	
Date of death		Place of death		Cause of death	
October 15, 1915		Boston, Mass.		Heart disease	
Time of death		Place of burial		Name of funeral director	
10:30 AM		Crown Hill Cemetery		J. H. Smith	
Signature of physician		Signature of registrar		Signature of undertaker	
[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]	
Date of registration		Place of registration		Name of registrar	
October 16, 1915		Boston, Mass.		J. H. Smith	
Signature of registrar		Signature of undertaker		Signature of funeral director	
[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]	

CERTIFICATE OF DEATH

Reg. Dist. No.

12603

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>1704 Noyes Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>MAY</u> Last <u>Connelly</u>				4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>fe</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/12/79</u>	9. AGE (In years last birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>David H. Pugh</u>				14. MOTHER'S MAIDEN NAME <u>MARY S. Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>PA's hosp. Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive Heart Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>Nov</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 21</u> , 19 <u>58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8901 Ga. av. Silver Spring Md.</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>Frank G. Leslie</u>				M.D. <u>8901 Ga. av. Silver Spring Md.</u>			
PHYSICIAN'S NAME (Type) <u>Frank G. Leslie</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>2901 14th St., N.W.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

NAME OF DECEASED _____		SEX _____		AGE _____		DATE OF BIRTH _____		PLACE OF BIRTH _____	
OCCUPATION _____		MARITAL STATUS _____		COLOR _____		RELIGION _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____		TIME OF DEATH _____		DATE OF DEATH _____		PLACE OF DEATH _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____		SIGNATURE OF JURY _____		SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____	
CERTIFICATE OF DEATH _____		CERTIFICATE OF DEATH _____		CERTIFICATE OF DEATH _____		CERTIFICATE OF DEATH _____		CERTIFICATE OF DEATH _____	

CHIEF CLERK
 BALTIMORE

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12660

CERTIFICATE OF DEATH

12641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle Coplin Last Coplin		4. DATE OF DEATH Month November Day 10 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12.8.80
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hezekiah Coplin		14. MOTHER'S MAIDEN NAME Amy Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 200.1 DUE TO Myocardial Infarction by Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphosarcoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days 4 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 58 , to Nov. 10 , 19 58 , that I last saw the deceased alive on Nov. 9 , 19 58 , and that death occurred at 5:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 N. Summit Ave., Gaithersburg, Md. DATE SIGNED 11-9-58 ACTUAL SIGNATURE Jack Schumacher M.D. PHYSICIAN'S NAME (Type) Jack Schumacher, M. D., Gaithersburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/58	
22c. NAME OF CEMETERY OR CREMATORY Brooke Grove., Laytonsville, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swords		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR NOV 17 '58		24b. REGISTRAR'S SIGNATURE Caroline S. Kline	

WIMBOLD

CERTIFICATE OF DEATH

STATE OF NEW YORK - BALTIC

1901

12661

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN TB 39 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico d. STREET ADDRESS 29 Triple Heights e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Isis Middle Maria Last CORREA		4. DATE OF DEATH Month November Day 1 Year 1958					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-52	9. AGE (In years last birthday) 6 yrs.	10. IF UNDER 1 YEAR Months 6 Days 6 Hours 6 Min. 6		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Brazil			
12. CITIZEN OF WHAT COUNTRY? Brazil							
13. FATHER'S NAME Diony CORREA			14. MOTHER'S MAIDEN NAME Elsa RODRIGUES				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Mr. Diony Correa, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cerebral hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). Leukemia, acute, myelomonocytic type DUE TO (c). INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 23 , 19 58 , to Nov. 1 , 19 58 , that I last saw the deceased alive on October 31 , 19 58 , and that death occurred at 4:57A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas E. Cone, Jr. M.D. U. S. Naval Hospital, NMMC 11-1-58							
ACTUAL SIGNATURE Thomas E. Cone, Jr. M.D. U. S. Naval Hospital, NMMC 11-1-58							
PHYSICIAN'S NAME (Type) Thomas E. CONE, Jr., CAPT, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-3-58		22c. NAME OF CEMETERY OR CREMATORY Rio de Janiero Brazil			
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler & Sons		ADDRESS 1756 Penn. Ave., NW, Wash., DC		24a. REC'D BY REGISTRAR NOV 3 '58			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the page 3 and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7

5.26

15-05-04

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818

1202

2005 4031

George J. Neocleous

1000 WEST 10TH AVE. • MT. PLEASANT, SD 57056

[illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>Washington Grove</u>			
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Agnes</u> Last <u>Cross</u>				4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2.14.95</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Albert Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Frances Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>Chronic Myocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/16/58</u> , 19 <u>58</u> , to <u>11/17/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/16/58</u> , 19 <u>58</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>L. I. Le</u> M.D.				PHYSICIAN'S NAME (Type) <u>L. I. Le</u> <u>Gaithersburg, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 19</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Providence</u>		22d. LOCATION (City, town, or county) (State) <u>Howard County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray Barber</u> ADDRESS <u>Laytonsville, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 20 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Heard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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PROVIDENCE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12663 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12644

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 wk</u>		d. STREET ADDRESS <u>12420 Dewey Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12420 Dewey Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Daniel Cunningham</u>		4. DATE OF DEATH <u>Nov 2 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-58</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Carl Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>Viola Jordan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Viola Cunningham</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH: <u>Found dead in bed</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-2-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2074276XV2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kentucky</u> b. COUNTY <u>Middlesboro</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>24 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middlesboro</u> <u>55 X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>209 East Chester Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Elizabeth</u> Last <u>Cunningham</u>				4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 22, 1940</u>	
9. AGE (In years last birthday) <u>18</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Leonard D. Cunningham</u>				14. MOTHER'S MAIDEN NAME <u>Inez Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unascertainable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tracheobronchial Obstruction</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Spontaneous Hemoptysis</u> DUE TO (c) <u>Congenital Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>45 minutes</u> <u>2 hours 20min.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 6, 1958</u> to <u>November 30, 1958</u> , that I last saw the deceased alive on <u>November 30, 1958</u> and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/30/58</u> NATIONAL INSTITUTES OF HEALTH <u>Bethesda 14, Maryland</u>							
ACTUAL SIGNATURE <u>William W. Pfaff</u>		PHYSICIAN'S NAME (Type) <u>William W. Pfaff, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cawood Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>Middlesboro Ky.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home 4812 Ga. Ave. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Place of registration: _____</p>	
<p>13. Name of informant: _____</p>		<p>14. Address of informant: _____</p>	
<p>15. Name of funeral home: _____</p>		<p>16. Address of funeral home: _____</p>	



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Montgomery</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>17 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash San Hosp.</u>				d. STREET ADDRESS <u>10203 Ridgemoor Dr.</u>			
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Isola</u> Last <u>Dankmeyer</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-73</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None. HOMEMAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>George Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Sarah J. HANEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO YES</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Chart + family</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>421.4 Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic valvular disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug. 1952</u> to <u>Nov. 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov-19</u> , 19 <u>58</u> , and that death occurred at <u>3:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10141 Colanville Rd Silver Spring, Md.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>A. L. Thibadeau</u> M.D.							
PHYSICIAN'S NAME (Type) <u>A. L. THIBADEAU</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 24 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur D. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12605 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12647

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, D.C.A.</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md. 1615.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San & Hospital</u>			d. STREET ADDRESS <u>2620 Kirkwood Pl.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>T</u> Last <u>DeLonge</u>			4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>58</u>		
5. SEX <u>m.</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1-58</u>		9. AGE (In years last birthday) yrs. <u>3</u> Months <u>16</u> Days <u>16</u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Chippewa Falls, Wisc.</u>	
13. FATHER'S NAME <u>Mr. Roland J. DeLonge</u>			14. MOTHER'S MAIDEN NAME <u>Barbara Ann Olson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Roland J. DeLonge</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>upper Resp. Infection</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>5 and 6 days in bed</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-17-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>transportation Nov 19, 1958</u>		22b. DATE THEREOF <u>Nov 19, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bloomer</u>	
22d. LOCATION (City, town, or county) (State) <u>Wisconsin</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

9VVVVVVVVVV

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS
DEPT. OF HEALTH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. PLACE OF DEATH</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL EXAMINER'S SIGNATURE</p>		<p>10. MEDICAL EXAMINER'S TITLE</p>	
<p>11. SIGNATURE OF NEXT OF KIN</p>		<p>12. SIGNATURE OF CLERK</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF JUDGE</p>	
<p>15. SIGNATURE OF SHERIFF</p>		<p>16. SIGNATURE OF CORONER</p>	
<p>17. SIGNATURE OF TOWNSHIP CLERK</p>		<p>18. SIGNATURE OF VOTING CLERK</p>	
<p>19. SIGNATURE OF TOWN CLERK</p>		<p>20. SIGNATURE OF COUNTY CLERK</p>	
<p>21. SIGNATURE OF STATE CLERK</p>		<p>22. SIGNATURE OF FEDERAL CLERK</p>	
<p>23. SIGNATURE OF POSTAL CLERK</p>		<p>24. SIGNATURE OF TELEGRAPH CLERK</p>	
<p>25. SIGNATURE OF RAILROAD CLERK</p>		<p>26. SIGNATURE OF STEAMSHIP CLERK</p>	
<p>27. SIGNATURE OF AIRLINE CLERK</p>		<p>28. SIGNATURE OF MARINE CLERK</p>	
<p>29. SIGNATURE OF NAVY CLERK</p>		<p>30. SIGNATURE OF ARMY CLERK</p>	
<p>31. SIGNATURE OF AIR FORCE CLERK</p>		<p>32. SIGNATURE OF SPACE CLERK</p>	
<p>33. SIGNATURE OF COAST GUARD CLERK</p>		<p>34. SIGNATURE OF CUSTOMS CLERK</p>	
<p>35. SIGNATURE OF EXCISE CLERK</p>		<p>36. SIGNATURE OF REVENUE CLERK</p>	
<p>37. SIGNATURE OF TREASURY CLERK</p>		<p>38. SIGNATURE OF DEPARTMENT CLERK</p>	
<p>39. SIGNATURE OF BUREAU CLERK</p>		<p>40. SIGNATURE OF OFFICE CLERK</p>	
<p>41. SIGNATURE OF FIELD CLERK</p>		<p>42. SIGNATURE OF DISTRICT CLERK</p>	
<p>43. SIGNATURE OF REGIONAL CLERK</p>		<p>44. SIGNATURE OF NATIONAL CLERK</p>	
<p>45. SIGNATURE OF INTERNATIONAL CLERK</p>		<p>46. SIGNATURE OF GLOBAL CLERK</p>	
<p>47. SIGNATURE OF PLANETARY CLERK</p>		<p>48. SIGNATURE OF GALACTIC CLERK</p>	
<p>49. SIGNATURE OF COSMIC CLERK</p>		<p>50. SIGNATURE OF UNIVERSE CLERK</p>	
<p>51. SIGNATURE OF MULTIVERSE CLERK</p>		<p>52. SIGNATURE OF INFINITE CLERK</p>	
<p>53. SIGNATURE OF OMNISCIENT CLERK</p>		<p>54. SIGNATURE OF OMnipotent CLERK</p>	
<p>55. SIGNATURE OF OMNIBENEFICENT CLERK</p>		<p>56. SIGNATURE OF OMNIPRESENT CLERK</p>	
<p>57. SIGNATURE OF OMNIPOTENT CLERK</p>		<p>58. SIGNATURE OF OMNISCIENT CLERK</p>	
<p>59. SIGNATURE OF OMNIBENEFICENT CLERK</p>		<p>60. SIGNATURE OF OMNIPRESENT CLERK</p>	
<p>61. SIGNATURE OF OMNIPOTENT CLERK</p>		<p>62. SIGNATURE OF OMNISCIENT CLERK</p>	
<p>63. SIGNATURE OF OMNIBENEFICENT CLERK</p>		<p>64. SIGNATURE OF OMNIPRESENT CLERK</p>	
<p>65. SIGNATURE OF OMNIPOTENT CLERK</p>		<p>66. SIGNATURE OF OMNISCIENT CLERK</p>	
<p>67. SIGNATURE OF OMNIBENEFICENT CLERK</p>		<p>68. SIGNATURE OF OMNIPRESENT CLERK</p>	
<p>69. SIGNATURE OF OMNIPOTENT CLERK</p>		<p>70. SIGNATURE OF OMNISCIENT CLERK</p>	
<p>71. SIGNATURE OF OMNIBENEFICENT CLERK</p>		<p>72. SIGNATURE OF OMNIPRESENT CLERK</p>	
<p>73. SIGNATURE OF OMNIPOTENT CLERK</p>		<p>74. SIGNATURE OF OMNISCIENT CLERK</p>	
<p>75. SIGNATURE OF OMNIBENEFICENT CLERK</p>		<p>76. SIGNATURE OF OMNIPRESENT CLERK</p>	
<p>77. SIGNATURE OF OMNIPOTENT CLERK</p>		<p>78. SIGNATURE OF OMNISCIENT CLERK</p>	
<p>79. SIGNATURE OF OMNIBENEFICENT CLERK</p>		<p>80. SIGNATURE OF OMNIPRESENT CLERK</p>	
<p>81. SIGNATURE OF OMNIPOTENT CLERK</p>		<p>82. SIGNATURE OF OMNISCIENT CLERK</p>	
<p>83. SIGNATURE OF OMNIBENEFICENT CLERK</p>		<p>84. SIGNATURE OF OMNIPRESENT CLERK</p>	
<p>85. SIGNATURE OF OMNIPOTENT CLERK</p>		<p>86. SIGNATURE OF OMNISCIENT CLERK</p>	
<p>87. SIGNATURE OF OMNIBENEFICENT CLERK</p>		<p>88. SIGNATURE OF OMNIPRESENT CLERK</p>	
<p>89. SIGNATURE OF OMNIPOTENT CLERK</p>		<p>90. SIGNATURE OF OMNISCIENT CLERK</p>	
<p>91. SIGNATURE OF OMNIBENEFICENT CLERK</p>		<p>92. SIGNATURE OF OMNIPRESENT CLERK</p>	
<p>93. SIGNATURE OF OMNIPOTENT CLERK</p>		<p>94. SIGNATURE OF OMNISCIENT CLERK</p>	
<p>95. SIGNATURE OF OMNIBENEFICENT CLERK</p>		<p>96. SIGNATURE OF OMNIPRESENT CLERK</p>	
<p>97. SIGNATURE OF OMNIPOTENT CLERK</p>		<p>98. SIGNATURE OF OMNISCIENT CLERK</p>	
<p>99. SIGNATURE OF OMNIBENEFICENT CLERK</p>		<p>100. SIGNATURE OF OMNIPRESENT CLERK</p>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12665 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12648

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE	c. LENGTH OF STAY IN 1b 4 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8804 WALNUT HILL ROAD		/d. STREET ADDRESS 8804 WALNUT HILL ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edwin Porter Denslow also known as		4. DATE OF DEATH Month Day Year Nov. 23 1958	
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/29/88
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed - never worked		10b. KIND OF BUSINESS OR INDUSTRY Conn.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LeGrand Norton Denslow		14. MOTHER'S MAIDEN NAME Mary Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Annelee Connors - Same Item 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 11/24/58	
EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/26/58	22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR NOV 26 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

MEDICAL CERTIFICATION

12666

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 38 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marion Middle (none) Last Dhein				4. DATE OF DEATH Month November Day 6 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1899	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 0 Hours 0 Min. 0		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		11. BIRTHPLACE (State or foreign country) Massachusetts	
10b. KIND OF BUSINESS OR INDUSTRY Education		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Donald C. MacPherson			
14. MOTHER'S MAIDEN NAME Margaret Graham		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-28-5186		17. INFORMATION The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X necrotizing pneumonia lt lung DUE TO (b) carcinoma of the breast DUE TO (c) 5 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X massive liver metastases							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) September 29, 1958		20g. (County) November 6, 1958		20h. (State) 9:40 P.M.	
21. I certify that I attended the deceased from September 29, 1958 to November 6, 1958 , that I last saw the deceased alive on November 6, 1958 and that death occurred at 9:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard H. Moy		M.D. The Clinical Center		ADDRESS (Street, city or town, state) The National Institutes of Health		DATE SIGNED 7/11/1958	
PHYSICIAN'S NAME (Type) Richard H. Moy, M.D.		Bethesda 14, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11/8/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawkins		24a. REC'D BY REGISTRAR NOV 12 '58	
24b. REGISTRAR'S SIGNATURE Arthur E. Hines		24c. ADDRESS 1756 Pa. Ave. NW		24d. DATE NOV 12 '58		24e. SIGNATURE Arthur E. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

1900

THE STATE OF NEW YORK, COUNTY OF ALBANY, City of Albany, ss.

I, the undersigned, a Justice of the Peace for the County of Albany, do hereby certify that

the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of Albany.

Witness my hand and the seal of my office this 1st day of January, 1900.

Attest:

My Commission Expires the 1st day of January, 1901.

Notary Public for the County of Albany.

My Commission Expires the 1st day of January, 1901.

Attest:

My Commission Expires the 1st day of January, 1901.

Notary Public for the County of Albany.

My Commission Expires the 1st day of January, 1901.

Attest:

My Commission Expires the 1st day of January, 1901.

Notary Public for the County of Albany.

My Commission Expires the 1st day of January, 1901.

Attest:

My Commission Expires the 1st day of January, 1901.

Notary Public for the County of Albany.

My Commission Expires the 1st day of January, 1901.

Attest:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12621

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12650

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glen Mill Rd.</u>		d. STREET ADDRESS <u>/ Glen Mill Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Dillard</u> Middle <u>Dillard</u> Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> , Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/76</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ill.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Winkelman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Puckett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Josiah Dillard</u>		Address <u>Same as Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Nov. 28, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 1, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home Washington D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1507

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
CAUSE OF DEATH									
MANNER OF DEATH									
SIGNATURE OF MEDICAL EXAMINER									
DATE OF EXAMINATION									
PLACE OF EXAMINATION									
CITY OF EXAMINATION									
COUNTY OF EXAMINATION									
STATE OF EXAMINATION									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12651

12667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Pittsylvania</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN lb <u>134</u> days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>Route #1, Box 100</u>			
3. NAME OF DECEASED (Type or print) First <u>Luther</u> Middle <u>Marvin</u> Last <u>Dowdy</u>				4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1902</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min. <u>56</u>		IF UNDER 24 HRS. Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Walter T. Dowdy</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. West</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unavailable</u>			
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Bleeding, Site undetermined</u> 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hodgkin's disease (Hepatic involvement)</u> DUE TO (c) <u>Pseudomonas Septicemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>14 Mo.</u> <u>10 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 7, 1958</u> , to <u>November 18, 1958</u> , that I last saw the deceased alive on <u>November 18, 1958</u> , and that death occurred at <u>1:30A M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Marsh</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/18/58</u>			
PHYSICIAN'S NAME (Type) <u>James M. Marsh, M.D.</u>				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Altavista, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wheatley Funeral Home</u> ADDRESS <u>809 King St. Va.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12668 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12652

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2316 Blue Ridge Ave</u>		d. STREET ADDRESS <u>2302 Blue Ridge Ave.</u>	
3. NAME OF DECEASED <u>ESTHER</u> First Middle Last <u>Esther Phoebe Draper</u>		4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-1914</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USC</u>	
13. FATHER'S NAME <u>Irvin Pitts</u>		14. MOTHER'S MAIDEN NAME <u>Raymond Dr</u> unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Raymond Draper</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>11/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>DEER CREEK, ILLINOIS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18

1902 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. OCCUPATION	
5. PLACE OF BIRTH		6. DATE OF DEATH		7. TIME OF DEATH		8. CAUSE OF DEATH	
9. PLACE OF DEATH		10. NAME OF PHYSICIAN		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF EXAMINER	
13. NAME OF FUNERAL HOME		14. NAME OF BURIAL PLACE		15. NAME OF CEMETERY		16. NAME OF INTERMENT	
17. NAME OF WITNESS		18. NAME OF WITNESS		19. NAME OF WITNESS		20. NAME OF WITNESS	
21. NAME OF WITNESS		22. NAME OF WITNESS		23. NAME OF WITNESS		24. NAME OF WITNESS	
25. NAME OF WITNESS		26. NAME OF WITNESS		27. NAME OF WITNESS		28. NAME OF WITNESS	
29. NAME OF WITNESS		30. NAME OF WITNESS		31. NAME OF WITNESS		32. NAME OF WITNESS	
33. NAME OF WITNESS		34. NAME OF WITNESS		35. NAME OF WITNESS		36. NAME OF WITNESS	
37. NAME OF WITNESS		38. NAME OF WITNESS		39. NAME OF WITNESS		40. NAME OF WITNESS	
41. NAME OF WITNESS		42. NAME OF WITNESS		43. NAME OF WITNESS		44. NAME OF WITNESS	
45. NAME OF WITNESS		46. NAME OF WITNESS		47. NAME OF WITNESS		48. NAME OF WITNESS	
49. NAME OF WITNESS		50. NAME OF WITNESS		51. NAME OF WITNESS		52. NAME OF WITNESS	
53. NAME OF WITNESS		54. NAME OF WITNESS		55. NAME OF WITNESS		56. NAME OF WITNESS	
57. NAME OF WITNESS		58. NAME OF WITNESS		59. NAME OF WITNESS		60. NAME OF WITNESS	
61. NAME OF WITNESS		62. NAME OF WITNESS		63. NAME OF WITNESS		64. NAME OF WITNESS	
65. NAME OF WITNESS		66. NAME OF WITNESS		67. NAME OF WITNESS		68. NAME OF WITNESS	
69. NAME OF WITNESS		70. NAME OF WITNESS		71. NAME OF WITNESS		72. NAME OF WITNESS	
73. NAME OF WITNESS		74. NAME OF WITNESS		75. NAME OF WITNESS		76. NAME OF WITNESS	
77. NAME OF WITNESS		78. NAME OF WITNESS		79. NAME OF WITNESS		80. NAME OF WITNESS	
81. NAME OF WITNESS		82. NAME OF WITNESS		83. NAME OF WITNESS		84. NAME OF WITNESS	
85. NAME OF WITNESS		86. NAME OF WITNESS		87. NAME OF WITNESS		88. NAME OF WITNESS	
89. NAME OF WITNESS		90. NAME OF WITNESS		91. NAME OF WITNESS		92. NAME OF WITNESS	
93. NAME OF WITNESS		94. NAME OF WITNESS		95. NAME OF WITNESS		96. NAME OF WITNESS	
97. NAME OF WITNESS		98. NAME OF WITNESS		99. NAME OF WITNESS		100. NAME OF WITNESS	

12669

CERTIFICATE OF DEATH

12653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE District of Columbia b. COUNTY Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47A-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 4701 Conn. Ave. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henrietta Middle Barber Last Ellis				4. DATE OF DEATH Month Nov. Day 26, Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1874		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 7 Days 22 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eckert J. Sacks				14. MOTHER'S MAIDEN NAME Henrietta Barber Loebischer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT George A. Sacks		Address 5517 Pembroke Rd. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 570.5 DUE TO Acute intestinal obstruction, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cause undetermined (c) cause undetermined PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right hemiparesis, cerebral aphasia due to old cerebrovascular disease						INTERVAL BETWEEN ONSET AND DEATH 2 AM - 8 AM, 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 26, 1958 to Nov. 26, 1958 , that I last saw the deceased alive on Nov. 26, 1958 , and that death occurred at 7:55 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George A. Brax Jr.		M.D. 104 Chevy Chase Dr. Chevy Chase, Md.					
PHYSICIAN'S NAME (Type) George A. Brax Jr.		ADDRESS 104 Chevy Chase Dr. Chevy Chase, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-28-58		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE NOV 28 1958	
				24b. REGISTRAR'S SIGNATURE Charles S. [illegible]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12670

CERTIFICATE OF DEATH

12654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montg</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring 56</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10602 Ambhurst Dr</i>				d. STREET ADDRESS <i>10602 Ambhurst Dr</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>ABRAHAM</i> Middle <i>H</i> Last <i>ELSBURG</i>				4. DATE OF DEATH Month <i>NOV</i> Day <i>17</i> Year <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 4 - 1908</i>	9. AGE (In years last birthday) <i>50</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Store clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <i>Baltimore MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel (Deceased)</i>				14. MOTHER'S MAIDEN NAME <i>Julia Klemman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-053694</i>		17. INFORMANT <i>Morris Elsborg</i> Address <i>Arlington Va</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension (longtime)</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July</i> , 1958, to <i>Nov. 17</i> , 1958, that I last saw the deceased alive on <i>Nov 17</i> , 1958, and that death occurred at <i>10:15 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John N. Andrews</i> M.D.				ADDRESS (Street, city or town, state) <i>9601 Colesville Rd Silver Spring Md</i>			
DATE SIGNED <i>11-17-58</i>							
PHYSICIAN'S NAME (Type) <i>John N. Andrews M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/18-1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Two Loash Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>Hyattsville Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home Wash. DC</i>				ADDRESS <i>Washington DC</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 18 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraw</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12671

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edgar Middle Morris Last Eshleman		4. DATE OF DEATH Month November Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11.27.79
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	11. BIRTHPLACE (State or foreign country) U. S. A.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Henry Eshleman	
14. MOTHER'S MAIDEN NAME Elizabeth Fritz		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the prostate DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastasis to CNS DUE TO (c) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH April 1956 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from April , 19 56 , to NOV , 19 58 , that I last saw the deceased alive on NOV. 4 , 19 58 , and that death occurred at 3:05 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE Lillian K. Ziegler M.D. _____		NOV 5, 1958	
PHYSICIAN'S NAME (Type) L. K. Ziegler, M. D.		Olney, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF NOV. 8/58	22c. NAME OF CEMETERY OR CREMATORY QUARRVILLE PA	22d. LOCATION (City, town, or county) (State) LANCASTER PA
23. FUNERAL DIRECTOR'S SIGNATURE Loyce Barber		ADDRESS Laytonsville, Md.	24a. REC'D BY REGISTRAR NOV 7 '58
		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

1911

MASSACHUSETTS
STATE DEPARTMENT OF HEALTH
BOSTON

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>	
<p>9. Signature of attending physician</p>		<p>10. Signature of registrar</p>	
<p>11. Date of registration</p>		<p>12. Signature of informant</p>	
<p>13. Address of informant</p>		<p>14. Signature of registrar</p>	
<p>15. Date of registration</p>		<p>16. Signature of registrar</p>	
<p>17. Address of informant</p>		<p>18. Signature of registrar</p>	
<p>19. Date of registration</p>		<p>20. Signature of registrar</p>	
<p>21. Address of informant</p>		<p>22. Signature of registrar</p>	
<p>23. Date of registration</p>		<p>24. Signature of registrar</p>	
<p>25. Address of informant</p>		<p>26. Signature of registrar</p>	
<p>27. Date of registration</p>		<p>28. Signature of registrar</p>	
<p>29. Address of informant</p>		<p>30. Signature of registrar</p>	
<p>31. Date of registration</p>		<p>32. Signature of registrar</p>	
<p>33. Address of informant</p>		<p>34. Signature of registrar</p>	
<p>35. Date of registration</p>		<p>36. Signature of registrar</p>	
<p>37. Address of informant</p>		<p>38. Signature of registrar</p>	
<p>39. Date of registration</p>		<p>40. Signature of registrar</p>	
<p>41. Address of informant</p>		<p>42. Signature of registrar</p>	
<p>43. Date of registration</p>		<p>44. Signature of registrar</p>	
<p>45. Address of informant</p>		<p>46. Signature of registrar</p>	
<p>47. Date of registration</p>		<p>48. Signature of registrar</p>	
<p>49. Address of informant</p>		<p>50. Signature of registrar</p>	
<p>51. Date of registration</p>		<p>52. Signature of registrar</p>	
<p>53. Address of informant</p>		<p>54. Signature of registrar</p>	
<p>55. Date of registration</p>		<p>56. Signature of registrar</p>	
<p>57. Address of informant</p>		<p>58. Signature of registrar</p>	
<p>59. Date of registration</p>		<p>60. Signature of registrar</p>	
<p>61. Address of informant</p>		<p>62. Signature of registrar</p>	
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<p>65. Address of informant</p>		<p>66. Signature of registrar</p>	
<p>67. Date of registration</p>		<p>68. Signature of registrar</p>	
<p>69. Address of informant</p>		<p>70. Signature of registrar</p>	
<p>71. Date of registration</p>		<p>72. Signature of registrar</p>	
<p>73. Address of informant</p>		<p>74. Signature of registrar</p>	
<p>75. Date of registration</p>		<p>76. Signature of registrar</p>	
<p>77. Address of informant</p>		<p>78. Signature of registrar</p>	
<p>79. Date of registration</p>		<p>80. Signature of registrar</p>	
<p>81. Address of informant</p>		<p>82. Signature of registrar</p>	
<p>83. Date of registration</p>		<p>84. Signature of registrar</p>	
<p>85. Address of informant</p>		<p>86. Signature of registrar</p>	
<p>87. Date of registration</p>		<p>88. Signature of registrar</p>	
<p>89. Address of informant</p>		<p>90. Signature of registrar</p>	
<p>91. Date of registration</p>		<p>92. Signature of registrar</p>	
<p>93. Address of informant</p>		<p>94. Signature of registrar</p>	
<p>95. Date of registration</p>		<p>96. Signature of registrar</p>	
<p>97. Address of informant</p>		<p>98. Signature of registrar</p>	
<p>99. Date of registration</p>		<p>100. Signature of registrar</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12672

CERTIFICATE OF DEATH

12656

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3604 Spring Street		d. STREET ADDRESS 3604 Spring Street	
3. NAME OF DECEASED (Type or print) First Middle Last ANN SUTHERLAND EVANS		4. DATE OF DEATH Month Day Year Nov. 3 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1877
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months 2 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Crissy		14. MOTHER'S MAIDEN NAME Sally Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Nancy Blair-daughter-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerotic cardiovascular disease DUE TO years (c) -----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from October, 1956 , to November, 1958 , that I last saw the deceased alive on November 3, 1958 , and that death occurred at 7:54 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1834 Eye St. N.W., Washington, D.C. 7822 Custer Road, Bethesda, Md.			
ACTUAL SIGNATURE George C. Buchanan		M.D. 1834 Eye St. N.W., Washington, D.C.	
PHYSICIAN'S NAME (Type) George C. Buchanan		7822 Custer Road, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/58	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Leesburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur L. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12673

CERTIFICATE OF DEATH

12657

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Rochester 10	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 76 Burrows Hills Drive	
3. NAME OF DECEASED (Type or print) First Stanley Middle Floyd Last Fairbanks		4. DATE OF DEATH Month November Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 28, 1951
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months 8 Days 7 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Carroll H. Fairbanks		14. MOTHER'S MAIDEN NAME Marjorie O. Speaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Soft ventricular dilatation & cardiac arrest 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital heart disease - mitral regurgitation DUE TO (c) Chronic congestive failure INTERVAL BETWEEN ONSET AND DEATH 30 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 8, 1958 , to November 5, 1958 , that I last saw the deceased alive on November 5, 1958 , and that death occurred at 3:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11/6/58 ACTUAL SIGNATURE William W. Pfaff, M.D. PHYSICIAN'S NAME (Type) William W. Pfaff, M. D. National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 11/8/58	
22c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery		22d. LOCATION (City, town, or county) (State) Williamson, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHORE, 12

12345

12345

NEW YORK STATE DEPARTMENT OF HEALTH
BALTHORE, 12

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Coroner		12. Signature of Medical Examiner	
13. Signature of Health Officer		14. Signature of County Clerk		15. Signature of City Clerk	
16. Signature of Mayor		17. Signature of Governor		18. Signature of President	
19. Signature of Vice President		20. Signature of Speaker of House		21. Signature of Senate President	
22. Signature of Chief Justice		23. Signature of Associate Justice		24. Signature of Justice	
25. Signature of Justice		26. Signature of Justice		27. Signature of Justice	
28. Signature of Justice		29. Signature of Justice		30. Signature of Justice	
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97. Signature of Justice		98. Signature of Justice		99. Signature of Justice	
100. Signature of Justice		101. Signature of Justice		102. Signature of Justice	

12674

CERTIFICATE OF DEATH

12658

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Howard Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenwood</u> <u>13x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hosp.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Henry</u> Last <u>Filling</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-13-93</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
13. FATHER'S NAME <u>Frank Ernest Filling</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Mae Forrest</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Nellie M. Filling, Glenwood, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 3, 1958</u> to <u>Nov. 9, 1958</u> , that I last saw the deceased alive on <u>November 9, 1958</u> , and that death occurred at <u>3:00 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u>				ADDRESS (Street, city or town, state) <u>Clarksville, Maryland</u> DATE SIGNED <u>11-10-58</u>			
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u>				24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK

County of ...

City of ...

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12606

CERTIFICATE OF DEATH

12659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>14 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Washington Sanatorium & Hospital</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Wheaton, Silver Spring</i>			
f. STREET ADDRESS <i>11810 Galt Ave</i>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>Louise</i> Last <i>Flanagan</i>				4. DATE OF DEATH Month <i>November</i> Day <i>25</i> Year <i>1958</i>			
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-14-80</i>	9. AGE (In years last birthday) <i>78</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>hours Schulte</i>				14. MOTHER'S MAIDEN NAME <i>Fredericka Redenzi</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>pl chart - pl</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma head of pancreas</i> <i>157x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes Mellitus</i> DUE TO (c) <i>Nephrotic Syndrome with terminal uremia</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260x</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>Feb 20</i> , 1958, to <i>Nov 25</i> , 1958, that I last saw the deceased alive on <i>Nov 24</i> , 1958, and that death occurred at <i>4:00 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Philip C. Jones</i>				ADDRESS (Street, city or town, state) <i>918 Ellsworth Drive Silver Spring, Md.</i>			
PHYSICIAN'S NAME (Type) <i>PHILIP E. JONES</i>				DATE SIGNED <i>11-25-58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11/26/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>PRINCE GEO. COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond W. Zurka</i>				24a. REC'D BY REGISTRAR DATE <i>NOV 26 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12675

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Annandale c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83x-3 d. STREET ADDRESS 2014 Bradford Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Robert FOSTER		4. DATE OF DEATH Month Day Year November 24 1958	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-04
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY U. S. Marine Corps	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph R. FOSTER		14. MOTHER'S MAIDEN NAME Antoinette KOEBICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1926 to 1956		16. SOCIAL SECURITY NO. (W) Mrs. Ruth M. Foster, same as #2 above	
17. INFORMANT Address (W) Mrs. Ruth M. Foster, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 20, 1958 , to November 24, 1958 , that I last saw the deceased alive on November 24, 1958 , and that death occurred at 11:06 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 11-25-58			
ACTUAL SIGNATURE J. T. Horgan		M.D. U. S. Naval Hospital, NMMC	
PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR, MC, USN		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-28-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Everly Funeral Home, 214 W. Main St., Fairfax, Va		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	
24a. REC'D BY REGISTRAR NOV 28 '58			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12661

12676

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 5721 Grosvenor Lane		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitarium & Hospital		d. STREET ADDRESS 4000 Mass. Ave., N.W.	
3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle FOSTER Last FOSTER		4. DATE OF DEATH Month November Day 20 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/18/1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Tennessee	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Malloy Foster		14. MOTHER'S MAIDEN NAME Talitha Jameson	
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Home Records - Bethesda, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomposition - 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Heart Disease DUE TO (c) Coronary Fibrosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Arterio-sclerosis -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/17/58 , 19 58 , to 11/20/58 , 19 58 , that I last saw the deceased alive on 11/20/58 , 19 58 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James A. O'Keefe M.D. 4545 Conn Ave NW Wash DC ACTUAL SIGNATURE James A. O'Keefe PHYSICIAN'S NAME (Type) James A. O'Keefe			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/22/58	
22c. NAME OF CEMETERY OR CREMATORY Lasting Hope		22d. LOCATION (City, town, or county) (State) Carters Creek, Tennessee	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		24a. REC'D BY REGISTRAR NOV 24 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12607 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12662

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Sen + Hosp</u>		d. STREET ADDRESS <u>127 Lexington Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>FISHER</u> Last <u>Frank</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>24</u> Year <u>19 58</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-84</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Asst.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Simon Fisher</u>		14. MOTHER'S MAIDEN NAME <u>KAROLINE FISHER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Chart</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull fracture & subdural hemorrhage</u> DUE TO (b) <u>Multiple contusions and lacerations of the brain</u> Conditions, if any, which gave rise to immediate cause (c) <u>Massive left hemothorax & rib fractures</u> cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian struck by auto</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:17</u> o.m. <u>11-24</u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Silver Spring montg</u> (County) <u>md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Boschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BOSCHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>KENSICO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>VALHALLA, NEW YORK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond G. Fiske</u>		24a. REC'D BY REGISTRAR <u>NOV 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>NOV 26 '58</u>	

MEDICAL CERTIFICATION

1999-2000

James Park

Is not Tom & Mary

1989

57

W M M

1957

47-22-21

25

10-11-1944

revised manuscript

10

Germany

Charles Fisher

1912

2000-2001

2/15/51

127 Lexington Drive

1894

12608

CERTIFICATE OF DEATH

Reg. Dist. No.

12663

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co. Takoma Park</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montgomery Co.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium & Hospital.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>William Earl French</i>				4. DATE OF DEATH Month Day Year <i>November 2 1958</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-4-1892</i>	9. AGE (In years last birthday) <i>66</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Architect</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ship Design.</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>us.</i>	
13. FATHER'S NAME <i>Christian Fenstermacher</i>				14. MOTHER'S MAIDEN NAME <i>Minerva Adams</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT Address <i>Grace B. French, same as above</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia.</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis.</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>2 months.</i> <i>2 years.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Sept. 28, 1958</i> to <i>Nov. 2, 1958</i> , that I last saw the deceased alive on <i>Nov. 2, 1958</i> , and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>C. W. Humphreys, Jr.</i> M.D.				ADDRESS (Street, city or town, state) <i>1746 K St. N.W.</i>		DATE SIGNED <i>11/3/58</i>	
PHYSICIAN'S NAME (Type) <i>C. W. Humphreys, Jr.</i>				<i>Washington C DC.</i>			
22a. BURIAL CREMATION <i>REMOVED</i>		22b. DATE THEREOF <i>11/5/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>George Wash. Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Pr. Geo. Co., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Co.</i>				24a. REC'D BY REGISTRAR <i>NOV 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12664

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
c. LENGTH OF STAY IN lb 11 years		d. STREET ADDRESS 123 Northwood Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Greene's Nursing Home - 14326 Colusville Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna L. Frye		4. DATE OF DEATH Month November Day 6 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1871
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 3 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Uriah S. Wolfe		14. MOTHER'S MAIDEN NAME Mary Jean Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. La Rue S. Jordan - 123 Northwood Ave. S. S.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 Month Nov Day 2 Year 1958	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 1957 , to November 6, 1958 , that I last saw the deceased alive on Nov 2 , 1958, and that death occurred at 6:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Aaron H. Traum		ADDRESS (Street, city or town, state) 8237 Georgia Ave - Silver Spring Md DATE SIGNED Nov 6 58	
PHYSICIAN'S NAME (Type) Aaron H. Traum			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 9, 1958	22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	22d. LOCATION (City, town, or county) Ship, Armstrong Co
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey Inc. 8434 Georgia Ave.			
24a. REC'D BY REGISTRAR DATE NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

12678

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Filing 237 12-19-58 et

Reg. Dist. No.

13917

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5411 Goldsboro Rd			d. STREET ADDRESS 5411 Goldsboro Rd,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Vander C. Middle Fulton Last			4. DATE OF DEATH Month Nov. Day 29, Year 1958		
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown	8. DATE OF BIRTH 3/ / 1906		9. AGE (In years last birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) handy man		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Williamsburg, Co. S. C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Peter Fulton			14. MOTHER'S MAIDEN NAME Sarah Fleming.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Police Record Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH Found dead on floor of his home.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipped		22b. DATE OF REMOVAL 12/2/58		22c. NAME OF CEMETERY OR CREMATORY Redmon Funeral Home.,	
22d. LOCATION (City, town, or county) King Street., S. C.		(State)		24a. REC'D BY REGISTRAR DEC 11 '58	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

2

EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEATH CERT.

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12679

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacoba Middle Francisca Last GERRITSEN		4. DATE OF DEATH Month November Day 4 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-22
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Holland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Johann AKELYEN		14. MOTHER'S MAIDEN NAME Cornelia MAYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 550-42-4066	
17. INFORMANT (H) John M. Gerritsen, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ruptured cerebral hemorrhage 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ruptured cerebral aneurysm DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 days 2 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 1 , 19 58 , to November 4 , 19 58 , that I last saw the deceased alive on November 3 , 19 58 , and that death occurred at 5:10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Matthew W. Wood MD M.D. U. S. Naval Hospital, NMHC 11-4-58 PHYSICIAN'S NAME (Type) M. W. WOOD, LCDR, MC, USN Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-58	
22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Newport News Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Riverside Funeral Home, Newport News, Va.		24a. REC'D BY REGISTRAR DATE NOV 5 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kious			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12666

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS 801 Northwest Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Wilma Anna Goodyear				4. DATE OF DEATH Month Day Year November 12 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/78	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Goodyear				14. MOTHER'S MAIDEN NAME Jennie Dunlop			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Right lung DUE TO (b) Tracheobronchitis DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 11/10 , 19 58 , to 11/12 , 19 58 , that I last saw the deceased alive on 11/12 , 19 58 , and that death occurred at 10:12am , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. 11/12/58 PHYSICIAN'S NAME (Type) G. H. Ligon, M. D. Sandy Spring, Maryland 22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 11/14/58 22c. NAME OF CEMETERY OR CREMATORY BLANDFORD CEMETERY 22d. LOCATION (City, town, or county) (State) PETERSBURG, VIRGINIA 23. FUNERAL DIRECTOR'S SIGNATURE Raymond W. Baska ADDRESS SILVER SPRING, MD. 24a. REC'D BY REGISTRAR DATE NOV 14 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Hanks							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Signature of informant

10. Signature of witness

11. Signature of funeral director

12. Signature of undertaker

13. Signature of cemetery

14. Signature of burial

15. Signature of interment

16. Signature of record

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12681

Items 8, 9 Film G23611-25-58 et

CERTIFICATE OF DEATH

12667

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN IB 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 4310 Locust Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas		First Thomas		Middle GORMAN		Lost November 14 19 58	
4. DATE OF DEATH November 14 19 58		Month November		Day 14		Year 19 58	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1876	
9. AGE (In years last birthday) 82 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael GORMAN		14. MOTHER'S MAIDEN NAME Margaret FITZGERALD		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes SpAm - WWI			
16. SOCIAL SECURITY NO. none		17. INFORMANT (W) Mrs. Clara B. Groman, same as #2 above		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE FAILURE DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 1 MONTH 70 YEARS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RECURRENT PNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 23, 19 58 to November 14, 19 58 , that I last saw the deceased alive on November 14, 19 58 , and that death occurred at 6:25P M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. S. Caldwell		M.D. U. S. Naval Hospital, NNMC		ADDRESS (Street, city or town, state) Bethesda, Maryland		DATE SIGNED 11-15-58	
PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington Virginia		23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		ADDRESS Bethesda, Md		24a. REC'D BY REGISTRAR NOV 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

CERTIFICATE OF DEATH

1901

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME

AGE

SEX

DATE OF DEATH

TIME

PLACE

CAUSE OF DEATH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12622 CERTIFICATE OF DEATH

12668

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rockville		LENGTH OF STAY (in this place) 5 Years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rockville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 813 North Washington				STREET ADDRESS (If rural give location) 813 North Washington			
3. NAME OF DECEASED (Type or Print) Nellie (First) Gray (Last)				4. DATE OF DEATH Nov. 5 1958 (Month) (Day) (Year)			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 8 1881	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Frances Evely			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Lloyd W. Gray Same A. 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Coronary Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis						10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Diabetes Mellitus						15 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 8 1881 , 19 58 , to Nov 5 1958 , 19 58 , that I last saw the deceased alive on Nov 5 1958 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state) [Address] DATE SIGNED [Date]			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 9		NAME OF CEMETERY OR CREMATORY Laytonsville, Meth.		LOCATION (City, town, or county) (State) Laytonsville, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Laytonsville, Md.	
DATE NOV 12 58							

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Usual Residence of Deceased

2. Date of Death

3. Place of Death

4. Cause of Death

5. Manner of Death

6. Age at Death

7. Sex

8. Race

9. Marital Status

10. Occupation

11. Date of Birth

12. Name of Physician

13. Name of Hospital

14. Name of Nurse

15. Name of Undertaker

16. Name of Coroner

17. Name of Registrar

18. Name of Medical Examiner

19. Name of Pathologist

20. Name of Forensic Pathologist

SHORTLY AFTER

This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her illness or at the time of death. It should be filled out as soon as possible after death, and should be filed with the local health department or the State Department of Health. The information on this certificate is used for statistical purposes only and is not to be used for legal purposes.

12682

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 4 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAPLE LANE NURSING HOME				e. STREET ADDRESS 8806 Manchester Road			
3. NAME OF DECEASED (Type or print) First SAMUEL Middle DORSEY Last GRIFFITH				4. DATE OF DEATH Month NOV. Day 19 Year 19 58			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/03	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Zone & Field Mgr.		10b. KIND OF BUSINESS OR INDUSTRY General Motors Corp.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL D. GRIFFITH				14. MOTHER'S MAIDEN NAME KATHERINE GLOCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) NO		16. SOCIAL SECURITY NO. 192-03-0539 H		17. INFORMANT Address Mrs. Sara F. Griffith, 8806 Manchester Rd. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from March 1956 to Nov 19, 1958 , that I last saw the deceased alive on Nov 19, 1958 , and that death occurred at 6:55 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John J. Curry		M.D. 10620 Georgia Ave		ADDRESS (Street, city or town, state) Silver Spring, Md		DATE SIGNED 11/19/58	
PHYSICIAN'S NAME (Type) JOHN J. CURRY							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/21/58	22c. NAME OF CEMETERY OR CREMATORY GRANDVIEW CEMETERY		22d. LOCATION (City, town, or county) (State) JOHNSTOWN, PENNSYLVANIA			
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Jiska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR NOV 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12683
CERTIFICATE OF DEATH

12670

Reg. Dist. No. **215**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 169 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) × Bethesda				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 3 Pooks Hill Road - Apt 316		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;">First IrvingMiddle GRODSTEINLast GRODSTEIN</div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-between;">Month NovemberDay 19Year 19 58</div>					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-7-15			
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner			10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel GRODSTEIN				14. MOTHER'S MAIDEN NAME Mary CANTERMAN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. WWII - KOREA 245-60-5473		17. INFORMANT Official Navy Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, colon, with generalized metastases 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div>							INTERVAL BETWEEN ONSET AND DEATH 1 yr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from June 3 , 19 58 , to November 19 , 19 58 , that I last saw the deceased alive on November 19 , 19 58 , and that death occurred at 1:30P M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Larry G. Hines</i>				ADDRESS (Street, city or town, state) U. S. Naval Hospital				DATE SIGNED 11-19-58	
PHYSICIAN'S NAME (Type) L. J. HINES, LCDR, MC, USN				Bethesda, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 11-21-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest P. Adams</i> Adams Funeral Home, 4748 Wisc. Ave., NW, Wash., DC				ADDRESS		24a. REC'D BY REGISTRAR NOV 21 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

12684

CERTIFICATE OF DEATH

Reg. Dist. No.

12671

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 1107 Rockville Pike	
3. NAME OF DECEASED (Type or print) First Gertrude Middle Herbert Last Gross		4. DATE OF DEATH Month November Day 22 Year 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1898
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR: Months 60 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) saleslady		10b. KIND OF BUSINESS OR INDUSTRY Delaware	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Herbert		14. MOTHER'S MAIDEN NAME Anna Yoski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT ANNA M. Williams - Daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized + cerebral arteriosclerosis DUE TO 260x Diabetes mellitus (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 15K 2 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1957 to Nov 22 1958 , that I last saw the deceased alive on Nov 22 1958 , and that death occurred at 9 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE H. Bonetto		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/26/58	22c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK	22d. LOCATION (City, town, or county) (State) BALTO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE Hortley Miller		24a. REC'D BY REGISTRAR DATE 11/25/58	
ADDRESS 2334 Jefferson St.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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12685

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edith Bruce Haas				4. DATE OF DEATH Month Day Year November 6 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/14/84 1883	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David S. Morse				14. MOTHER'S MAIDEN NAME Edith M. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Hospital Records Olney, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized, advanced, arterio-sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 58 , to Nov , 19 58 , that I last saw the deceased alive on Nov 5 , 19 58 , and that death occurred at 5:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE A. D. Bonifant M.D.							
PHYSICIAN'S NAME (Type) A. D. Bonifant, M.D. Sandy Spring, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/8/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				24a. REC'D BY REGISTRAR DATE NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4: may be retained by the hospital or attending physician.

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MAILED 11 1964
FBI - NEW YORK
CONFIDENTIAL

RECEIVED
FBI - NEW YORK
NOV 11 1964

1964

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1. Name of Deceased JAMES EARL RAY		2. Date of Birth 5-10-28	
3. Sex Male		4. Race White	
5. Date of Death 6-28-68		6. Place of Death Memphis, Tennessee	
7. Cause of Death Suicide		8. Manner of Death Homicide	
9. Signature of Physician J. Edgar Hoover		10. Signature of Registrar J. Edgar Hoover	
11. Signature of Coroner J. Edgar Hoover		12. Signature of Medical Examiner J. Edgar Hoover	
13. Signature of Funeral Home J. Edgar Hoover		14. Signature of Burial Place J. Edgar Hoover	
15. Signature of Cemetery J. Edgar Hoover		16. Signature of Interment J. Edgar Hoover	
17. Signature of Burial Place J. Edgar Hoover		18. Signature of Interment J. Edgar Hoover	
19. Signature of Cemetery J. Edgar Hoover		20. Signature of Interment J. Edgar Hoover	
21. Signature of Burial Place J. Edgar Hoover		22. Signature of Interment J. Edgar Hoover	
23. Signature of Cemetery J. Edgar Hoover		24. Signature of Interment J. Edgar Hoover	
25. Signature of Burial Place J. Edgar Hoover		26. Signature of Interment J. Edgar Hoover	
27. Signature of Cemetery J. Edgar Hoover		28. Signature of Interment J. Edgar Hoover	
29. Signature of Burial Place J. Edgar Hoover		30. Signature of Interment J. Edgar Hoover	
31. Signature of Cemetery J. Edgar Hoover		32. Signature of Interment J. Edgar Hoover	
33. Signature of Burial Place J. Edgar Hoover		34. Signature of Interment J. Edgar Hoover	
35. Signature of Cemetery J. Edgar Hoover		36. Signature of Interment J. Edgar Hoover	
37. Signature of Burial Place J. Edgar Hoover		38. Signature of Interment J. Edgar Hoover	
39. Signature of Cemetery J. Edgar Hoover		40. Signature of Interment J. Edgar Hoover	
41. Signature of Burial Place J. Edgar Hoover		42. Signature of Interment J. Edgar Hoover	
43. Signature of Cemetery J. Edgar Hoover		44. Signature of Interment J. Edgar Hoover	
45. Signature of Burial Place J. Edgar Hoover		46. Signature of Interment J. Edgar Hoover	
47. Signature of Cemetery J. Edgar Hoover		48. Signature of Interment J. Edgar Hoover	
49. Signature of Burial Place J. Edgar Hoover		50. Signature of Interment J. Edgar Hoover	
51. Signature of Cemetery J. Edgar Hoover		52. Signature of Interment J. Edgar Hoover	
53. Signature of Burial Place J. Edgar Hoover		54. Signature of Interment J. Edgar Hoover	
55. Signature of Cemetery J. Edgar Hoover		56. Signature of Interment J. Edgar Hoover	
57. Signature of Burial Place J. Edgar Hoover		58. Signature of Interment J. Edgar Hoover	
59. Signature of Cemetery J. Edgar Hoover		60. Signature of Interment J. Edgar Hoover	
61. Signature of Burial Place J. Edgar Hoover		62. Signature of Interment J. Edgar Hoover	
63. Signature of Cemetery J. Edgar Hoover		64. Signature of Interment J. Edgar Hoover	
65. Signature of Burial Place J. Edgar Hoover		66. Signature of Interment J. Edgar Hoover	
67. Signature of Cemetery J. Edgar Hoover		68. Signature of Interment J. Edgar Hoover	
69. Signature of Burial Place J. Edgar Hoover		70. Signature of Interment J. Edgar Hoover	
71. Signature of Cemetery J. Edgar Hoover		72. Signature of Interment J. Edgar Hoover	
73. Signature of Burial Place J. Edgar Hoover		74. Signature of Interment J. Edgar Hoover	
75. Signature of Cemetery J. Edgar Hoover		76. Signature of Interment J. Edgar Hoover	
77. Signature of Burial Place J. Edgar Hoover		78. Signature of Interment J. Edgar Hoover	
79. Signature of Cemetery J. Edgar Hoover		80. Signature of Interment J. Edgar Hoover	
81. Signature of Burial Place J. Edgar Hoover		82. Signature of Interment J. Edgar Hoover	
83. Signature of Cemetery J. Edgar Hoover		84. Signature of Interment J. Edgar Hoover	
85. Signature of Burial Place J. Edgar Hoover		86. Signature of Interment J. Edgar Hoover	
87. Signature of Cemetery J. Edgar Hoover		88. Signature of Interment J. Edgar Hoover	
89. Signature of Burial Place J. Edgar Hoover		90. Signature of Interment J. Edgar Hoover	
91. Signature of Cemetery J. Edgar Hoover		92. Signature of Interment J. Edgar Hoover	
93. Signature of Burial Place J. Edgar Hoover		94. Signature of Interment J. Edgar Hoover	
95. Signature of Cemetery J. Edgar Hoover		96. Signature of Interment J. Edgar Hoover	
97. Signature of Burial Place J. Edgar Hoover		98. Signature of Interment J. Edgar Hoover	
99. Signature of Cemetery J. Edgar Hoover		100. Signature of Interment J. Edgar Hoover	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12686

CERTIFICATE OF DEATH

12673

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1 hr. 28 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital Inc.		d. STREET ADDRESS Woodbine Box 14	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Harrison		4. DATE OF DEATH Month 11.28. Day 19 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11.28.58
9. AGE (In years lost birthday) yrs. 1 Min. 28		IF UNDER 1 YEAR Months 1 Days 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James H. Harrison		14. MOTHER'S MAIDEN NAME Edna R. Riggleman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Hospital Records.	
17. INFORMANT Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Bilateral atelectasis DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 1 1/2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/28 , 19 58 , to 11/28 , 19 58 , that I last saw the deceased alive on 11/28 , 19 58 , and that death occurred at 11:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		DATE SIGNED 11/30/58	
PHYSICIAN'S NAME (Type) James P. Kerr, M. D.		ADDRESS (Street, city or town, state) Damascus, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov.30,1958	
22c. NAME OF CEMETERY OR CREMATORY True Gospel Cemetery		22d. LOCATION (City, town, or county) (State) Lisbon, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Molsworth		24a. REC'D BY REGISTRAR Damascus, Md.	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE DEC 2 '58	

2073/71XVI

11. 330 HTLAS-HTLADH TO TREAT AND CURE CHOLERA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12674

12687

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 30 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Falls Church c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83x-3	
3. NAME OF DECEASED (Type or print) Sadie First Middle Last Mae HARVEY		4. DATE OF DEATH Month Day Year November 3 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-90
9. AGE (In years last birthday) 68/68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael MC CARTHY		14. MOTHER'S MAIDEN NAME Nora MC GOUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 549 16 6781A	
17. INFORMANT (D) Mrs. Patricia M. Hansen Same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma, Breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 4 , 19 58 , to November 3 , 19 58 , that I last saw the deceased alive on November 3 , 19 58 , and that death occurred at 9:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NNMC, 11-3-58			
ACTUAL SIGNATURE Robert C. Thomas		PHYSICIAN'S NAME (Type) ROBERT C. THOMAS LT MC USN Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-58	
22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Parsons Kansas	
23. FUNERAL DIRECTOR'S SIGNATURE P. J. SAFFELL		24a. REC'D BY REGISTRAR Nov 5 1958	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. ADDRESS 475 H. St., N. W., Washington, D. C.	

CERTIFICATE OF DEATH

1917

Residence (House)

10-10-17

U. S. Naval Hospital

Leslie

Female

10-10-17

John

Residence

Residence 10-10-17

10-10-17

() 10-10-17

Residence 10-10-17

Residence 10-10-17

Residence 10-10-17

Residence 10-10-17

Residence 10-10-17

Residence 10-10-17

Residence 10-10-17

U. S. Naval Hospital, BALTIMORE

Residence 10-10-17

Residence 10-10-17

Residence 10-10-17

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12688 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12675

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Germantown (rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban				f. STREET ADDRESS 1111 D. 2 Box 30		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice Christine Hawkins				4. DATE OF DEATH Month Nov. Day 10 Year 19 58			
5. SEX r	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1937		9. AGE (In years last birthday) 20 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY DEATH PLACE (State or foreign country) Germantown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Martha Hawkins - same				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Gladys Hawkins (sister) Address Same as above.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 491x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral confluent broncho-pneumonia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/58		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park,		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville		24a. REC'D BY REGISTRAR NOV 17 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. House			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12689

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>69 days</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kentucky</u> b. COUNTY <u>Madisonville</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 x 3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			d. STREET ADDRESS <u>204 South Franklin Street</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruby Cordelia Hawkins</u>			4. DATE OF DEATH Month Day Year <u>November 23, 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1898</u>		9. AGE (In years last birthday) <u>60 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>George West Cooke</u>			14. MOTHER'S MAIDEN NAME <u>Cordelia Sisk</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>404-12-7490</u>	17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the thyroid gland</u> <u>194x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>with laryngotracheal obstruction</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September 15, 1958</u> , to <u>November 23, 1958</u> , that I last saw the deceased alive on <u>November 23, 1958</u> and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>James A. Rose, M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>11/24/58</u> <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>James A. Rose, M. D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>11/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Madisonville, Kentucky</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 26 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12690
CERTIFICATE OF DEATH

12677

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 41 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 8613 Melwood Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edward Everett HAZLETT, JR.		4. DATE OF DEATH Month Day Year November 2 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-29-92
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Everett HAZLETT		14. MOTHER'S MAIDEN NAME Alice Elizabeth MOTT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWI - WWII		16. SOCIAL SECURITY NO. (W) Mrs. Eliz. Hazlett, same as #2 above	
17. INFORMANT (W) Mrs. Eliz. Hazlett, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 22 , 19 58 , to November 2 , 19 58 , that I last saw the deceased alive on November 1 , 19 58 , and that death occurred at 7:35A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. E. Richardson		DATE SIGNED 11-3-58	
PHYSICIAN'S NAME (Type) H. E. RICHARDSON, CAPT, MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		24a. REC'D BY REGISTRAR NOV 5 '58	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12678

12691

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 35yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS 1-Montgomery Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Millard ^{First} Edward ^{Middle} Heim ^{Last}			4. DATE OF DEATH Nov 26 Day 26 Year 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 24-1882		9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months 6 Days 2 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	
13. FATHER'S NAME Edward L. Heim			12. CITIZEN OF WHAT COUNTRY? U S A		
14. MOTHER'S MAIDEN NAME Malinda S. Kemp					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Bessie E. Heim. Address Rockville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 24 hrs 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-22 , 19 58 , to 11-26 , 19 58 , that I last saw the deceased alive on 11-26 , 19 58 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg Md DATE SIGNED 11-27-58					
ACTUAL SIGNATURE F. J. Bloesch M.D.		SIGNATURE Arthur S. Kraus			
PHYSICIAN'S NAME (Type) F. J. Bloesch					
22a. BURIAL, CREMATION, REMOVAL Burial	22b. DATE THEREOF 11-28-58	22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner ADDRESS Gaithersburg Md.			24a. REC'D BY REGISTRAR DATE DEC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12679

12692

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 25 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,213 GEORGIA AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle CHARLES Last HEITMULLER		4. DATE OF DEATH Month NOVEMBER Day 9 Year 19 58	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/6/69
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Produce	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES HEITMULLER		14. MOTHER'S MAIDEN NAME CAROLINE HEITMULLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Minna E. Heitmuller, 10,213 Ga. Ave. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Kidney Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Heart Disease 1 week (c) Peripheral Arterio Sclerosis Sept with gangrene 2 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
19. INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/1/52 , 19____, to 11/9/58 , 19____, that I last saw the deceased alive on 11/9/58 , 19____, and that death occurred at 12:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md DATE SIGNED 11/9/58			
ACTUAL SIGNATURE John J. Curry M.D.		DATE SIGNED 11/9/58	
PHYSICIAN'S NAME (Type) JOHN J. CURRY		ADDRESS Silver Spring, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/11/58	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziskar		24a. REC'D BY REGISTRAR DATE NOV 12 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12693

CERTIFICATE OF DEATH

Reg. Dist. No.

12680

1. PLACE OF DEATH a. COUNTY <u>Montg</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg, Rural</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ann Higgins</u>			4. DATE OF DEATH Month Day Year <u>Nov 18 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28-1873</u>		9. AGE (In years last birthday) <u>85</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Work</u>	11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>6 22</u>
13. FATHER'S NAME <u>Thomas Gorman</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>John M. Higgins, Gaithersburg, Rural Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>20 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. s. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 2, 1957</u> to <u>Nov. 17, 1958</u> , that I last saw the deceased alive on <u>Nov. 17, 1958</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>G. Bowditch Hunter, Jr.</u> M.D.			ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd.; Rockville Md.</u> DATE SIGNED <u>11/17/58</u>		
PHYSICIAN'S NAME (Type) <u>G. Bowditch Hunter, Jr.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-21-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg, Md.</u>			24a. REC'D BY REGISTRAR <u>NOV 21 1958</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Hunter</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12694 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12681

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
c. LENGTH OF STAY IN lb <u>life</u>		d. STREET ADDRESS <u>10500 McArthur Blvd. (unit 14) DC.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10500 McArthur Blvd. (unit 14) DC.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence Leonard Hill</u>		4. DATE OF DEATH <u>Nov 24 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-7-86</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR <u>0</u> Months <u>7</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levy D. Hill</u>		14. MOTHER'S MAIDEN NAME <u>Julie Marston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>	
17. INFORMANT <u>Rose Hill (wife)</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>976X Abdominal hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>shot gun wound in upper abdomen</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted shot gun wound</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:15 p.m. 11-24 1958</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Cabin John</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-24-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Church</u>		22d. LOCATION (City, town, or county) <u>Potomac, Maryland</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>NOV 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

12041

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

18004 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
USE ONLY

[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, cause of death, and examiner details.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12682

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (rural) R-2				d. STREET ADDRESS (rural) R-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ella Blanche Hill				4. DATE OF DEATH Month Nov. Day 30 , Year 1958			
5. SEX female	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/1892	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY Id.		11. BIRTHPLACE (State or foreign country) Id.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Wilson				14. MOTHER'S MAIDEN NAME Eliza Dove			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous C.V.A. about 7 mo. ago.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/30/58			
EXAMINER'S NAME (Type) Frank J. Broschart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REINTERMENT (If any) Burial		22b. DATE THEREOF 12/3/58		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park,		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE DEC 5 '58	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kras</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12696

CERTIFICATE OF DEATH

12683

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7108 Oak Forest Lane</u>				e. STREET ADDRESS <u>7108 Oak Forest Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Della Hoffman</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/1876</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Melvin Dreisbach</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mr. Clifford Battles</u>		Address <u>7108 Oak Forest Lane Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cerebral Arteriosclerosis &</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aneurysm thoracic aorta</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/2</u> 19 <u>58</u> , to <u>11/20</u> 19 <u>58</u> , that I last saw the deceased alive on <u>11/19</u> 19 <u>58</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>W. Luther Hall</u> M.D. <u>1150 Conn Ave</u>				DATE SIGNED <u>11/20/58</u>			
PHYSICIAN'S NAME (Type) <u>W. Luther Hall</u> <u>Wash. 6, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>11/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Barberton, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clifford S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12684

12697

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg,</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Rural. Gmo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Linwood</u> Middle <u>Howard</u> Last <u>Howard</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>15th</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4-1874</u>
9. AGE (In years lost birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Montg Co, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Daniel F. Howard</u>		14. MOTHER'S MAIDEN NAME <u>Mary Frances Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Donald S. Howard. Gaithersburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO VASCULAR ACCIDENT</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u> <u>YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE ARTERIOSCLEROSIS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/29</u> , 19 <u>58</u> , to <u>11/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/15</u> , 19 <u>58</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10211 Georgia Ave Silver Spring Maryland</u> DATE SIGNED <u>11/16/58</u>			
ACTUAL SIGNATURE <u>Henry W. Stout MD</u>			
PHYSICIAN'S NAME (Type) <u>HENRY W. STOUT MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

5125

12698

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 46 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Marshall c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cameron d. STREET ADDRESS 19 Fleming Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Walter Elbert HOWARD				4. DATE OF DEATH Month Day Year November 30 19 58			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-6-99	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diplomatic Service				10b. KIND OF BUSINESS OR INDUSTRY U.S. State Dept.			
13. FATHER'S NAME George HOWARD				14. MOTHER'S MAIDEN NAME Sarah DAYTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 235-24-8436		17. INFORMANT Address (W) Mrs. Mary Opal Howard, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma to the liver 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary Bronchogenic Carcinoma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 11 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 15, 19 58 to November 30, 19 58 , that I last saw the deceased alive on November 30, 19 58 , and that death occurred at 6:30P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. G. Muth				DATE SIGNED 12-1-58			
PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN				ADDRESS (Street, city or town, state) Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-3-58		22c. NAME OF CEMETERY OR CREMATORY Halcyon Hills Memorial Gardens		22d. LOCATION (City, town, or county) (State) Wheeling W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS Funeral Home, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE DEC 3 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 5 and 6 should be filed with the funeral director.

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12699

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6109 Greentree Road, Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) 6109 Greentree Rd.,		e. STREET ADDRESS 6109 Greentree Road	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT LE ROY HUGHES		4. DATE OF DEATH Month Day Year Nov. 8, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1888
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months 3 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Hughes		14. MOTHER'S MAIDEN NAME Laura V. Goggin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 577-03-0261	
17. INFORMANT Son -		Address Same as Item 1.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY FAILURE 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DISSEMINATED CARCINOMATOSIS DUE TO (c) CARCINOMA OF THE STOMACH.		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. NONE 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCTOBER 9, 1958 , to NOVEMBER 8, 1958 , that I last saw the deceased alive on NOVEMBER 7, 1958 , and that death occurred at 3:20 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11/8/58 DATE SIGNED SUITE 400, 8218 WISCONSIN AVE.			
ACTUAL SIGNATURE Edward S. Witowski, Jr. M.D.		PHYSICIAN'S NAME (Type) EDWARD S. WITOWSKI, JR. M.D. BETHESDA 19, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR NOV 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knead	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12700
CERTIFICATE OF DEATH

12687

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4905 Battery Lane		d. STREET ADDRESS 4905 Battery Lane	
3. NAME OF DECEASED (Type or print) JAMES First E. Middle HUTCHINSON Last		4. DATE OF DEATH November 29, Month 1958 Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1878
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months 5 Days 21 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Pat. Atty.		10b. KIND OF BUSINESS OR INDUSTRY Own business	11. BIRTHPLACE (State or foreign country) Washington, D. C.
13. FATHER'S NAME James E. Hutchinson, Sr.		14. MOTHER'S MAIDEN NAME Harriett Randall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. J. E. Hutchinson-same as #2 wife
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4341 DUE TO Septicemia of heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive failure of heart & high blood pressure (c) Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH Immediate 6 mos. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 35 , to 11/29 , 19 58 , that I last saw the deceased alive on 11/26 , 19 58 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Emmett E. Corner M.D.		ADDRESS (Street, city or town, state) 2601 Bradley Pl. N.W. DATE SIGNED	
PHYSICIAN'S NAME (Type) Emmett E. Corner		"Park" W. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/2/58	22c. NAME OF CEMETERY OR CREMATORY Congressional Cem.	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DEC 3 '58	24b. REGISTRAR'S SIGNATURE Arthur E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01874

4581.8 g/ml.

James S. Watson, Jr.

12701

CERTIFICATE OF DEATH

12688

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>13315 Lydia St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JENNIE G. ISACS</u>				4. DATE OF DEATH <u>Nov-16-1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN-10-1891</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK-NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MOSES GINSBURG</u>				14. MOTHER'S MAIDEN NAME <u>LINA Bloom</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHARLOTTE KUPPER (SANE)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>34 hrs.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 20</u> , 19 <u>58</u> , to <u>Nov 16</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>Nov 16</u> , 19 <u>58</u> , and that death occurred at <u>6:40</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. L. Tabb</u>				ADDRESS (Street, city or town, state) <u>13000 Georgia Ave. S.W. Sp. 10</u>			
PHYSICIAN'S NAME (Type) <u>S. L. TABB</u>				DATE SIGNED <u>11/16/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Judah Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>NEW YORK, NY.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Sons</u>				ADDRESS <u>3501-14th St. N.W. Wash DC.</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

CERTIFICATE OF DEATH

1971

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>10/15/1925</i></p>		<p>4. Place of birth: <i>New York, N.Y.</i></p>	
<p>5. Date of death: <i>11/10/1971</i></p>		<p>6. Place of death: <i>Baltimore, Md.</i></p>	
<p>7. Cause of death: <i>Myocardial Infarction</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Physician's name: <i>Dr. J. Smith</i></p>		<p>10. Hospital name: <i>St. Mary's Hospital</i></p>	
<p>11. Signature of physician: <i>[Signature]</i></p>		<p>12. Signature of registrar: <i>[Signature]</i></p>	
<p>13. Date of registration: <i>11/15/1971</i></p>		<p>14. Registrar's name: <i>John Doe</i></p>	

12702

CERTIFICATE OF DEATH

12689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 31 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 605 Sligo Avenue			
d. STREET ADDRESS 1 605 Sligo Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jacob Middle Iseli Last Iseli				4. DATE OF DEATH Month NOVEMBER Day 1 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/1/91	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN				10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (State or foreign country) SWITZERLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN FIGHTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 577-01-8799		17. INFORMANT Mrs. Marie R. Iseli, 605 Sligo Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Right hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Hypertension (c) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 3 hours Undetermined Undetermined			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 11, 1954 to Nov 1, 1958 that I last saw the deceased alive on Nov 1, 1958 and that death occurred at 10:20 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George L. Ball M.D.				ADDRESS (Street, city or town, state) 7835 Eastern Ave Nov 2, 1958			
PHYSICIAN'S NAME (Type) George L. Ball				DATE SIGNED Silver Spring Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 11/4/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGES COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond B. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE NOV 5 '58	
				24b. REGISTRAR'S SIGNATURE Charles E. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15029

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

1917

Reg. Dist. No.

1. NAME OF DECEASED JOHN J. SMITH		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH Jan 15 1917		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Myocardial Infarction	
9. TIME OF DEATH 10:00 AM		10. SIGNATURE OF PHYSICIAN J. H. Smith	
11. SIGNATURE OF REGISTRAR J. H. Smith		12. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
13. SIGNATURE OF CORONER J. H. Smith		14. SIGNATURE OF JURY J. H. Smith, J. H. Smith	
15. SIGNATURE OF DECEASED J. H. Smith		16. SIGNATURE OF SURVIVORS J. H. Smith, J. H. Smith	
17. SIGNATURE OF NEAREST RELATIVE J. H. Smith		18. SIGNATURE OF CLERGYMAN J. H. Smith	
19. SIGNATURE OF MINISTER J. H. Smith		20. SIGNATURE OF CHURCH J. H. Smith	
21. SIGNATURE OF FUNERAL HOME J. H. Smith		22. SIGNATURE OF BURIAL PLACE J. H. Smith	
23. SIGNATURE OF INTERMENT J. H. Smith		24. SIGNATURE OF CREMATION J. H. Smith	
25. SIGNATURE OF CEMETERY J. H. Smith		26. SIGNATURE OF URBAN INTERMENT J. H. Smith	
27. SIGNATURE OF RURAL INTERMENT J. H. Smith		28. SIGNATURE OF OTHER INTERMENT J. H. Smith	
29. SIGNATURE OF OTHER INTERMENT J. H. Smith		30. SIGNATURE OF OTHER INTERMENT J. H. Smith	
31. SIGNATURE OF OTHER INTERMENT J. H. Smith		32. SIGNATURE OF OTHER INTERMENT J. H. Smith	
33. SIGNATURE OF OTHER INTERMENT J. H. Smith		34. SIGNATURE OF OTHER INTERMENT J. H. Smith	
35. SIGNATURE OF OTHER INTERMENT J. H. Smith		36. SIGNATURE OF OTHER INTERMENT J. H. Smith	
37. SIGNATURE OF OTHER INTERMENT J. H. Smith		38. SIGNATURE OF OTHER INTERMENT J. H. Smith	
39. SIGNATURE OF OTHER INTERMENT J. H. Smith		40. SIGNATURE OF OTHER INTERMENT J. H. Smith	
41. SIGNATURE OF OTHER INTERMENT J. H. Smith		42. SIGNATURE OF OTHER INTERMENT J. H. Smith	
43. SIGNATURE OF OTHER INTERMENT J. H. Smith		44. SIGNATURE OF OTHER INTERMENT J. H. Smith	
45. SIGNATURE OF OTHER INTERMENT J. H. Smith		46. SIGNATURE OF OTHER INTERMENT J. H. Smith	
47. SIGNATURE OF OTHER INTERMENT J. H. Smith		48. SIGNATURE OF OTHER INTERMENT J. H. Smith	
49. SIGNATURE OF OTHER INTERMENT J. H. Smith		50. SIGNATURE OF OTHER INTERMENT J. H. Smith	
51. SIGNATURE OF OTHER INTERMENT J. H. Smith		52. SIGNATURE OF OTHER INTERMENT J. H. Smith	
53. SIGNATURE OF OTHER INTERMENT J. H. Smith		54. SIGNATURE OF OTHER INTERMENT J. H. Smith	
55. SIGNATURE OF OTHER INTERMENT J. H. Smith		56. SIGNATURE OF OTHER INTERMENT J. H. Smith	
57. SIGNATURE OF OTHER INTERMENT J. H. Smith		58. SIGNATURE OF OTHER INTERMENT J. H. Smith	
59. SIGNATURE OF OTHER INTERMENT J. H. Smith		60. SIGNATURE OF OTHER INTERMENT J. H. Smith	
61. SIGNATURE OF OTHER INTERMENT J. H. Smith		62. SIGNATURE OF OTHER INTERMENT J. H. Smith	
63. SIGNATURE OF OTHER INTERMENT J. H. Smith		64. SIGNATURE OF OTHER INTERMENT J. H. Smith	
65. SIGNATURE OF OTHER INTERMENT J. H. Smith		66. SIGNATURE OF OTHER INTERMENT J. H. Smith	
67. SIGNATURE OF OTHER INTERMENT J. H. Smith		68. SIGNATURE OF OTHER INTERMENT J. H. Smith	
69. SIGNATURE OF OTHER INTERMENT J. H. Smith		70. SIGNATURE OF OTHER INTERMENT J. H. Smith	
71. SIGNATURE OF OTHER INTERMENT J. H. Smith		72. SIGNATURE OF OTHER INTERMENT J. H. Smith	
73. SIGNATURE OF OTHER INTERMENT J. H. Smith		74. SIGNATURE OF OTHER INTERMENT J. H. Smith	
75. SIGNATURE OF OTHER INTERMENT J. H. Smith		76. SIGNATURE OF OTHER INTERMENT J. H. Smith	
77. SIGNATURE OF OTHER INTERMENT J. H. Smith		78. SIGNATURE OF OTHER INTERMENT J. H. Smith	
79. SIGNATURE OF OTHER INTERMENT J. H. Smith		80. SIGNATURE OF OTHER INTERMENT J. H. Smith	
81. SIGNATURE OF OTHER INTERMENT J. H. Smith		82. SIGNATURE OF OTHER INTERMENT J. H. Smith	
83. SIGNATURE OF OTHER INTERMENT J. H. Smith		84. SIGNATURE OF OTHER INTERMENT J. H. Smith	
85. SIGNATURE OF OTHER INTERMENT J. H. Smith		86. SIGNATURE OF OTHER INTERMENT J. H. Smith	
87. SIGNATURE OF OTHER INTERMENT J. H. Smith		88. SIGNATURE OF OTHER INTERMENT J. H. Smith	
89. SIGNATURE OF OTHER INTERMENT J. H. Smith		90. SIGNATURE OF OTHER INTERMENT J. H. Smith	
91. SIGNATURE OF OTHER INTERMENT J. H. Smith		92. SIGNATURE OF OTHER INTERMENT J. H. Smith	
93. SIGNATURE OF OTHER INTERMENT J. H. Smith		94. SIGNATURE OF OTHER INTERMENT J. H. Smith	
95. SIGNATURE OF OTHER INTERMENT J. H. Smith		96. SIGNATURE OF OTHER INTERMENT J. H. Smith	
97. SIGNATURE OF OTHER INTERMENT J. H. Smith		98. SIGNATURE OF OTHER INTERMENT J. H. Smith	
99. SIGNATURE OF OTHER INTERMENT J. H. Smith		100. SIGNATURE OF OTHER INTERMENT J. H. Smith	

TO BE FILLED BY CLERK OF DISTRICT

12609

CERTIFICATE OF DEATH

12690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK 12				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLLEGE PARK, MARYLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN & HOSP.				d. STREET ADDRESS 3120 POWDER MILL RD			
3. NAME OF DECEASED (Type or print) First Middle Last ANNA AMELIA JACKSON				4. DATE OF DEATH Month Day Year 11 - 10 1958			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-67	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U-S-A	
13. FATHER'S NAME MR. MORGLE			14. MOTHER'S MAIDEN NAME ELIZA. Part name not known				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address WASHINGTON SAN & HOSP. RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Age - Emaciation							INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 58 , to 11-10 , 19 58 , that I last saw the deceased alive on 11-10 , 19 58 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. E. POYNE				ADDRESS (Street, city or town, state) 7600 Carroll Ave. Takoma Park, Md.			
PHYSICIAN'S NAME (Type) A. E. POYNE				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE NOV 13 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12610 CERTIFICATE OF DEATH

12691

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>14 1/2 hrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San'y Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>INDIANA</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anderson</u> <u>51X-3</u> d. STREET ADDRESS <u>835 W. 2nd STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Virgil</u> <u>C/AlRE</u> <u>Jenkins</u>		4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1958</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>11/17/19</u> 9. AGE (In years last birthday) <u>38</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanics</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>1</u> 11. BIRTHPLACE (State or foreign country) <u>Wyoming</u> 12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>Arthur Jenkins</u> 14. MOTHER'S MAIDEN NAME <u>Lillie Hamilton</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Pl's hosp Record.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung with Metastases</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 yr</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 14</u> , 19 <u>58</u> , to <u>Nov 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>58</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>James W. O. [Signature]</u> M.D. <u>7701 Carroll Ave</u> <u>11-15-58</u> PHYSICIAN'S NAME (Type) <u>TAKOMA PARK, MD</u>		22a. BURIAL, CREMATION, or other disposal <u>17-58</u> 22b. DATE THEREOF <u>11-17-58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u> 22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>251 Carroll St. N.W.</u> <u>D.C.</u> 24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Christina S. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers.

12703

CERTIFICATE OF DEATH

12692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. ERIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> 13X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Russell Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carter</u> First <u>Johnson</u> Middle Last		4. DATE OF DEATH <u>11</u> <u>15</u> 19 <u>58</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1905</u> <u>53</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>John Henry Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Celia (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Brother Ellicott City</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Cerebral Embolism</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auricular Fibrillation</u> DUE TO <u>Hypertension, Essential</u> (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-2-58</u> 19 <u>58</u> , to <u>11-15</u> 19 <u>58</u> , that I last saw the deceased alive on <u>11-15</u> 19 <u>58</u> , and that death occurred at <u>5:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clive E. Jackson</u> M.D.		ADDRESS (Street, city or town, state) <u>R.P. 1, Gaithersburg, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST LOUIS</u>	22d. LOCATION (City, town, or county) (State) <u>CLARKSVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. H. K. K. BATHON</u> ADDRESS <u>ELICOTT CITY MD</u>		24a. REC'D BY REGISTRAR <u>NOV 18 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12704

CERTIFICATE OF DEATH

Reg. Dist. No.

12693

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN Ib 8 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9412 Flower Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9412 Flower Avenue		d. STREET ADDRESS 1 9412 Flower Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BESSIE TEMPERANCE JOHNSTON		4. DATE OF DEATH Month NOV. Day 13 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/79
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS N. SCHROYER		14. MOTHER'S MAIDEN NAME TOBITHA RAMSEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Herbert A. Johnston, 9412 Flower Ave. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446x DUE TO PREMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) NEPHROSCLEROSIS (c) 3 yrs. INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEP. 19 57 to NOV. 13, 19 58 that I last saw the deceased alive on 13 Nov. 19 58 and that death occurred at 4 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE LBSnow M.D.		ADDRESS (Street, city or town, state) 9013 FLOWER AVE. SILVER SPRING, MD. DATE SIGNED 7/14/58	
PHYSICIAN'S NAME (Type) L. B. SNOW			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/17/58	
22c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Mem. Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23a. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Ziska INC		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12705

12694

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 10 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1012 W. Nolcrest Drive				e. STREET ADDRESS 1012 W. Nolcrest Drive			
3. NAME OF DECEASED (Type or print) First PEARL Middle SABIN Last JONES				4. DATE OF DEATH Month NOVEMBER Day 2 Year 58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 9, 1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE BROKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ST. JOSEPH, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES ALDRICH SABIN				14. MOTHER'S MAIDEN NAME MARY WELCH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Stanley S. Jones, 1012 W. Nolcrest Drive Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 722.0 - Cardiorespiratory insufficiency DUE TO - generalized toxemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) due to kidney insufficiency DUE TO chronic severe degenerative rheumatoid arthritis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe other poisons						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from Jan. 15, 1956 to Oct 31, 1958 , that I last saw the deceased alive on Oct. 31, 1958 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10401 N. H. Ave. Silver Spring, Maryland DATE SIGNED VERONICA TROOST							
ACTUAL SIGNATURE VERONICA TROOST		M.D. 10401 N. H. Ave. Silver Spring, Maryland					
PHYSICIAN'S NAME (Type) VERONICA TROOST							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/4/58	22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Zick				24a. REC'D BY REGISTRAR DATE NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

Reg. Dist. No. 12695

12706

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPING				c. LENGTH OF STAY IN 1b 7 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. PHILOMENA REST HOME				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47x-3			
f. STREET ADDRESS 3901 Langley Court, N.W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle Last KANE				4. DATE OF DEATH Month NOV. Day 15 Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/70	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener (retired)		10b. KIND OF BUSINESS OR INDUSTRY Gardening		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Kane				14. MOTHER'S MAIDEN NAME Bridgett Murphy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Edward F. Kane, 3901 Langley Court, N.W. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO approx 30yrs. (c) Septicemia 2 wks.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 3, 1958 , to Nov. 15, 1958 , that I last saw the deceased alive on Nov. 7, 1958 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2205 Richland St. DATE SIGNED							
ACTUAL SIGNATURE Harry J. Kicheter M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) HARRY J. Kicheter				Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
TRANS. & BURIAL		11/16/58		ST. ANN'S CATHOLIC CEMETERY		LENOX, MASS.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE NOV 19 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18708

12883

Reg. No. 111

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. TIME OF DEATH</p> <p>10. SIGNATURE OF PHYSICIAN</p> <p>11. SIGNATURE OF REGISTRAR</p> <p>12. SIGNATURE OF WITNESSES</p> <p>13. SIGNATURE OF DECEASED</p> <p>14. SIGNATURE OF NEXT OF KIN</p> <p>15. SIGNATURE OF BURIAL SOCIETY</p> <p>16. SIGNATURE OF CHURCH</p> <p>17. SIGNATURE OF FUNERAL HOME</p> <p>18. SIGNATURE OF CEMETERY</p> <p>19. SIGNATURE OF INTERVIEWER</p> <p>20. SIGNATURE OF SUPERVISOR</p> <p>21. SIGNATURE OF ASSISTANT SUPERVISOR</p> <p>22. SIGNATURE OF CLERK</p> <p>23. SIGNATURE OF RECEPTIONIST</p> <p>24. SIGNATURE OF TELEPHONE OPERATOR</p> <p>25. SIGNATURE OF MAIL ROOM</p> <p>26. SIGNATURE OF RECORDS SECTION</p> <p>27. SIGNATURE OF IDENTIFICATION SECTION</p> <p>28. SIGNATURE OF INVESTIGATION SECTION</p> <p>29. SIGNATURE OF LABORATORY SECTION</p> <p>30. SIGNATURE OF RADIOLOGY SECTION</p> <p>31. SIGNATURE OF PATHOLOGY SECTION</p> <p>32. SIGNATURE OF ANATOMY SECTION</p> <p>33. SIGNATURE OF PHYSIOLOGY SECTION</p> <p>34. SIGNATURE OF PSYCHOLOGY SECTION</p> <p>35. SIGNATURE OF SOCIOLOGY SECTION</p> <p>36. SIGNATURE OF ANTHROPOLOGY SECTION</p> <p>37. SIGNATURE OF LINGUISTICS SECTION</p> <p>38. SIGNATURE OF PHILOSOPHY SECTION</p> <p>39. SIGNATURE OF HISTORY SECTION</p> <p>40. SIGNATURE OF GEOGRAPHY SECTION</p> <p>41. SIGNATURE OF POLITICAL SCIENCE SECTION</p> <p>42. SIGNATURE OF ECONOMICS SECTION</p> <p>43. SIGNATURE OF LAW SECTION</p> <p>44. SIGNATURE OF MEDICINE SECTION</p> <p>45. SIGNATURE OF NURSING SECTION</p> <p>46. SIGNATURE OF DENTISTRY SECTION</p> <p>47. SIGNATURE OF VETERINARY SECTION</p> <p>48. SIGNATURE OF AGRICULTURE SECTION</p> <p>49. SIGNATURE OF FISHERIES SECTION</p> <p>50. SIGNATURE OF FORESTRY SECTION</p> <p>51. SIGNATURE OF MINING SECTION</p> <p>52. SIGNATURE OF MANUFACTURES SECTION</p> <p>53. SIGNATURE OF TRANSPORTATION SECTION</p> <p>54. SIGNATURE OF COMMUNICATIONS SECTION</p> <p>55. SIGNATURE OF PUBLIC UTILITIES SECTION</p> <p>56. SIGNATURE OF ENVIRONMENTAL SECTION</p> <p>57. SIGNATURE OF NATURAL RESOURCES SECTION</p> <p>58. SIGNATURE OF CULTURAL HERITAGE SECTION</p> <p>59. SIGNATURE OF RECREATION SECTION</p> <p>60. SIGNATURE OF TOURISM SECTION</p> <p>61. SIGNATURE OF EDUCATION SECTION</p> <p>62. SIGNATURE OF LABOR SECTION</p> <p>63. SIGNATURE OF SOCIAL WELFARE SECTION</p> <p>64. SIGNATURE OF COMMUNITY DEVELOPMENT SECTION</p> <p>65. SIGNATURE OF PLANNING SECTION</p> <p>66. SIGNATURE OF ZONING SECTION</p> <p>67. SIGNATURE OF BUILDING SECTION</p> <p>68. SIGNATURE OF FIRE PROTECTION SECTION</p> <p>69. SIGNATURE OF POLICE SECTION</p> <p>70. SIGNATURE OF JUDICIAL SECTION</p> <p>71. SIGNATURE OF LEGISLATIVE SECTION</p> <p>72. SIGNATURE OF EXECUTIVE SECTION</p> <p>73. SIGNATURE OF ADMINISTRATIVE SECTION</p> <p>74. SIGNATURE OF FINANCIAL SECTION</p> <p>75. SIGNATURE OF PERSONNEL SECTION</p> <p>76. SIGNATURE OF TRAINING SECTION</p> <p>77. SIGNATURE OF RESEARCH SECTION</p> <p>78. SIGNATURE OF EVALUATION SECTION</p> <p>79. SIGNATURE OF MONITORING SECTION</p> <p>80. SIGNATURE OF REPORTING SECTION</p> <p>81. SIGNATURE OF RECORDS SECTION</p> <p>82. SIGNATURE OF COMMUNICATIONS SECTION</p> <p>83. SIGNATURE OF PUBLIC AFFAIRS SECTION</p> <p>84. SIGNATURE OF OUTREACH SECTION</p> <p>85. SIGNATURE OF PARTNERSHIP SECTION</p> <p>86. SIGNATURE OF COOPERATION SECTION</p> <p>87. SIGNATURE OF COLLABORATION SECTION</p> <p>88. SIGNATURE OF CONSULTATION SECTION</p> <p>89. SIGNATURE OF PARTICIPATION SECTION</p> <p>90. SIGNATURE OF ENGAGEMENT SECTION</p> <p>91. SIGNATURE OF INVOLVEMENT SECTION</p> <p>92. SIGNATURE OF COMMITMENT SECTION</p> <p>93. SIGNATURE OF RESPONSIBILITY SECTION</p> <p>94. SIGNATURE OF ACCOUNTABILITY SECTION</p> <p>95. SIGNATURE OF TRANSPARENCY SECTION</p> <p>96. SIGNATURE OF INTEGRITY SECTION</p> <p>97. SIGNATURE OF ETHICS SECTION</p> <p>98. SIGNATURE OF HONESTY SECTION</p> <p>99. SIGNATURE OF FAIRNESS SECTION</p> <p>100. SIGNATURE OF JUSTICE SECTION</p>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12696

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Rockingham</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisonburg</u> 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>500 Green Street</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>KENNEDY</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 30 1958</u>
9. AGE (In years lost birthday) yrs. <u>2</u> <u>15</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLEATUS LEE KENNEDY</u>		14. MOTHER'S MAIDEN NAME <u>EVELYN MARIE COOKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MOTHER</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Summertime</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Levin - 5 months gestation</u> DUE TO (c) <u>Birth weight - 1 lb. 15 g.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/30</u> , 19 <u>58</u> , to <u>11/30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/30</u> , 19 <u>58</u> , and that death occurred at <u>5A</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. P. Lenthner</u>		ADDRESS (Street, city or town, state) <u>26 N. Summit St., Harrisonburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Hoy W. Barber</u>		DATE SIGNED <u>11/30/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 1</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville, Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hoy W. Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE DEC 2 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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MARIANO STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12697

1. PLACE OF DEATH o. COUNTY <u>Hootanery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>VIRGINIA</u> b. COUNTY <u>ROCKINGHAM</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRISONBURG 83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>500 GREEN ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY GIRL KENNEDY</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 30 1958</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>CLEATUS LEE KENNEDY</u>		14. MOTHER'S MAIDEN NAME <u>ERLYN MARIE COOKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>MOTHER</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity -</u> DUE TO <u>Swamp - 5 months gestation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Birth weight - 1 lb 8 oz.</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 30</u> , 19 <u>58</u> , to <u>Nov 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 30</u> , 19 <u>58</u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Lenthorn</u>		ADDRESS (Street, city or town, state) <u>26 N. Summit St., Baltimore, Md.</u>	
DATE SIGNED <u>11/30/58</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dr. Royce Barber, Laytonville, Md.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 1</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laytonville, Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Laytonville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Royce Barber, Laytonville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

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CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text: ...]</p>		<p>2. SEX [Faint text: ...]</p>	
<p>3. AGE [Faint text: ...]</p>		<p>4. DATE OF BIRTH [Faint text: ...]</p>	
<p>5. PLACE OF BIRTH [Faint text: ...]</p>		<p>6. OCCUPATION [Faint text: ...]</p>	
<p>7. MARITAL STATUS [Faint text: ...]</p>		<p>8. CAUSE OF DEATH [Faint text: ...]</p>	
<p>9. MEDICAL HISTORY [Faint text: ...]</p>		<p>10. DATE OF DEATH [Faint text: ...]</p>	
<p>11. PLACE OF DEATH [Faint text: ...]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint text: ...]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint text: ...]</p>		<p>14. DATE OF REGISTRATION [Faint text: ...]</p>	

12709

CERTIFICATE OF DEATH

12698

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington, Virginia</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium.</u>				d. STREET ADDRESS <u>83x-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Cecelia</u> Middle <u>L.</u> Last <u>Kent</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 2, 1880</u>	
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>		IF UNDER 24 HRS. Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Iowa</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Jacques Loizeux</u>				14. MOTHER'S MAIDEN NAME <u>Olive Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Chart. Carleton Kent-4609 5-3419 St.</u>		17. INFORMANT <u>Chart. Carleton Kent-4609 5-3419 St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>904 Fractured L. Femur</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>904 Fractured L. Femur</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>53</u> , to <u>11-20-</u> 19 <u>58</u> , that I last saw the deceased alive on <u>11-19-58</u> , 19 <u>58</u> , and that death occurred at <u>12:30P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lewis H. Biben</u>				ADDRESS (Street, city or town, state) <u>915 19TH ST NW</u>			
PHYSICIAN'S NAME (Type) <u>LEWIS H. BIBEN</u>				DATE SIGNED <u>11/20/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>NOV 21, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH F BIRCHERSONS</u>				ADDRESS <u>3034 M St NW</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12611

CERTIFICATE OF DEATH

12699

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. SAN. & Hospt.				d. STREET ADDRESS 19211 Wire Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIAM Middle GILBERT Last KERR				4. DATE OF DEATH Month Nov Day 15 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. NEVER NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 27, 1876	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer Retd.				10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.		11. BIRTHPLACE (State or foreign country) W. Va	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Harold J. Kerr				14. MOTHER'S MAIDEN NAME Clara Gilbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Sp. Amer.				16. SOCIAL SECURITY NO. None		17. INFORMANT Hosp. Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 12 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August , 19 58 , to November , 19 58 , that I last saw the deceased alive on Nov. 14 , 19 58 , and that death occurred at 3 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard A. Fitzgerald M.D.				ADDRESS (Street, city or town, state) 217 University Blvd E. Silver Spring, Md.			
DATE SIGNED 4/15/58							
PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/58		22c. NAME OF CEMETERY OR CREMATORY Morningside		22d. LOCATION (City, town, or county) (State) Clearfield Co., Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE NOV 19 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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M

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VS A15 (4)
15M 10/57

12710

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12700

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Rhode Island b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 98 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 222 Saratoga Street	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Francis Kerwin		4. DATE OF DEATH Month Day Year November 5, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1896
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motor Stripper		10b. KIND OF BUSINESS OR INDUSTRY Electric	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kerwin		14. MOTHER'S MAIDEN NAME Elizabeth Farrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 037-01-1022	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hodgkin's Disease, Universal DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 10 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 30, 1958 , to November 5, 1958 , that I last saw the deceased alive on November 5, 1958 , and that death occurred at 2:05 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harold R. Silberman M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) HAROLD R. SILBERMAN, M.D.		DATE SIGNED 11/5/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 10/58	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Providence, Rhode Island
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson Co.		24a. REC'D BY REGISTRAR NOV 10 1958	24b. REGISTRAR'S SIGNATURE Arthur S. Kins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased

Residence

Date of Death

Place of Death

Signature of Physician

Signature of Registrar

Age

Sex

Place of Birth

Signature of Deceased

Signature of Next of Kin

Signature of Minister

Signature of Burial

Signature of Undertaker

Signature of Coroner

Signature of Medical Examiner

Signature of Registrar

Signature of Minister

Signature of Deceased

Signature of Next of Kin

Signature of Minister

Signature of Burial

Signature of Undertaker

Signature of Coroner

Signature of Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12711

CERTIFICATE OF DEATH

12701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 1 Mo.-22 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville d. STREET ADDRESS 1103 Highland Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alvin Middle C. Last Ketcham		4. DATE OF DEATH Month Nov. Day 16 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1896
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 10 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Own business	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME H urlings Ketcham		14. MOTHER'S MAIDEN NAME Sarah Farley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WWI	
17. INFORMANT Phila. 44, Pa.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Intracerebral Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) 2. Internal Hydrocephalus DUE TO (c) 3. Diverticulosis (Descending & Sig moid Colon) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from Sept 5, 1958 to Nov. 16, 1958 , that I last saw the deceased alive on Nov. 15, 1958 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur F. Woodward M.D.		ADDRESS (Street, city or town, state) Rockville - Md DATE SIGNED 11/16/58	
PHYSICIAN'S NAME (Type) Arthur F. Woodward		Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/20/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia (State) 	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR NOV 19 '58 DATE 	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1971

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1970

<p>1. Name of deceased: <u>JOHN DOE</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>12/15/1925</u></p>		<p>4. Place of birth: <u>NEW YORK, N.Y.</u></p>	
<p>5. Date of death: <u>10/10/1970</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>10/15/1970</u></p>		<p>12. Office of registration: <u>BALTIMORE</u></p>	

3.1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12612 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 3 1/2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 111 GRANT AVENUE			d. STREET ADDRESS 111 GRANT AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EMMA Middle KIESELHORST Last			4. DATE OF DEATH Month NOV. Day 17 Year 1958		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/8/85		9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) HEIDELBERG, GERMANY		12. CITIZEN OF WHAT COUNTRY? GERMANY ✓
13. FATHER'S NAME WILHELM KIESELHORST			14. MOTHER'S MAIDEN NAME AUGUSTA (unknown)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mrs. Eleanor Anna Wilson, 111 Grant Ave. Takoma Park, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/18/58	
EXAMINER'S NAME (Type) Frank J. Broschart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/20/58	22c. NAME OF CEMETERY OR CREMATORY WASHINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE NOV 19 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12712

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12703

Item 2, Film G236, 12/5/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington Washington	
c. LENGTH OF STAY IN 1b 5 yrs		d. Kensington Gardens San.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens San.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Kimball Last Kimball		4. DATE OF DEATH Nov. 28, 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/1872
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Idaho	
11. BIRTHPLACE (State or foreign country) Idaho		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Spaulding		14. MOTHER'S MAIDEN NAME Anne Allmon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO. Sanatarium Records	
17. INFORMANT Sanatarium Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma of left breast with metastasis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 mos.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/ 28/ 58	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12/1/1958	22c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery	22d. LOCATION (City, town, or county) (State) Pasadena, California
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR DATE 1 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

2

FOR STATE
HEALTH DEPT

12312

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12312

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1950		Home	
Cause of Death		Disease		Organ		Site		Nature	
Myocardial Infarction		Coronary Artery Disease		Heart		Left Ventricle		Atherosclerosis	
Contributing Factors		Hypertension		Diabetes Mellitus		Smoking		Obesity	
Time of Death		Place of Death		Physician		Manner of Death		Signature of Examiner	
10:00 AM		Home		Dr. J. Smith		Natural		[Signature]	
Burial		Cremation		Other		Disposition of Body		Disposition of Organs	
Buried		Cremated		None		None		None	
Burial Place		Crematorium		Other		Disposition of Body		Disposition of Organs	
St. Mary's Cemetery		St. Mary's Crematorium		None		None		None	
Burial Date		Cremation Date		Other Date		Disposition of Body		Disposition of Organs	
Jan 15, 1950		Jan 15, 1950		None		None		None	
Burial Time		Cremation Time		Other Time		Disposition of Body		Disposition of Organs	
10:00 AM		10:00 AM		None		None		None	
Burial Place		Crematorium		Other		Disposition of Body		Disposition of Organs	
St. Mary's Cemetery		St. Mary's Crematorium		None		None		None	
Burial Date		Cremation Date		Other Date		Disposition of Body		Disposition of Organs	
Jan 15, 1950		Jan 15, 1950		None		None		None	
Burial Time		Cremation Time		Other Time		Disposition of Body		Disposition of Organs	
10:00 AM		10:00 AM		None		None		None	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12713

CERTIFICATE OF DEATH

12704

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gregory Middle George Last Kotishion		4. DATE OF DEATH Month November Day 18 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1950
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Kotishion		14. MOTHER'S MAIDEN NAME Norma Austin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Rt. ventricular failure DUE TO (b) Cardiac surgery DUE TO (c) Multiple congenital cardiac anomalies Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 30 min. 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 16, 1958 , to November 18, 1958 , that I last saw the deceased alive on November 18, 1958 , and that death occurred at 1:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William W. Pfaff M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 11/18/58	
PHYSICIAN'S NAME (Type) William W. Pfaff M.D.		The Clinical Center The National Institutes of Health Bethesda 14, Maryland	
22a. TIME OF REMOVAL (Specify)	22b. DATE THEREOF 11-21-58	22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S UKRAINIAN GREEK CATH. CEMETERY	22d. LOCATION (City, town, or county) (State) MeAdoo, PA.
23. FUNERAL DIRECTOR'S SIGNATURE Green Funeral Home		24a. REC'D BY REGISTRAR NOV 20 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kiana

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

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DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

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PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12613
CERTIFICATE OF DEATH

12705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park - 12 Wash				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. & Hosp. Tr. P. 12				d. STREET ADDRESS 3292 Chestnut St. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARENCE Thomas LACY				4. DATE OF DEATH Nov-8 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-'71	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder - retired		10b. KIND OF BUSINESS OR INDUSTRY Builder		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Henry Lacy				14. MOTHER'S MAIDEN NAME Annie Payne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Hospital Records Address 			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Pneumonia - R + the L Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic Bronchitis (b) Pneumonia (c) Chronic Bronchitis + Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 4-5 mos	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Possible malignancy	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/9/58 to 11/8/58 that I last saw the deceased alive on 11/8/58 , 19 58 , and that death occurred at 12 PM M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas H Vololon				ADDRESS (Street, city or town, state) 7600 Carroll Ave DATE SIGNED 11/8/58			
PHYSICIAN'S NAME (Type) Chas H Vololon				ADDRESS Suburban Park Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/11/58		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. A. News Co. ADDRESS 2901-14th St. N.W. Wash., DC				24a. REC'D BY REGISTRAR DATE NOV 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Brown	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12714

CERTIFICATE OF DEATH

12706

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson--Rural		c. LENGTH OF STAY IN lb 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson--Rural		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Viola Virginia Lambert		First Middle Last		4. DATE OF DEATH Month Day Year Nov 8 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9--1866		9. AGE (In years last birthday) yrs. 92	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME William Sarver		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Wesley Lambert, Poolesville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio sclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 16 hours 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 1 , 19 58 to 8 Nov , 19 58 , that I last saw the deceased alive on 8 Nov , 19 58 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md DATE SIGNED 9 Nov 58 ACTUAL SIGNATURE Gordon M. Smith M.D. PHYSICIAN'S NAME (Type) Gordon M. Smith							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 11-58		22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton Barnesville, Md				24a. REC'D BY REGISTRAR DATE NOV 13 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

VS A15 (4)
ISM 10/57

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>		e. STREET ADDRESS <u>4918 Montgomery Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Phillip</u> First Middle Last		4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1954</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold G. Langmaid</u>		14. MOTHER'S MAIDEN NAME <u>Helen Mazza</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harold G. Langmaid</u>		Address <u>4918 Montgomery Lane Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushed skull</u> DUE TO <u>Backed over by truck</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Crushed face and fracture of left jaw</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Backed over by truck</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9:55</u> <u>11/8/58</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Building Devp.</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Nov. 8, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12707

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
John Doe		45		Male		White		1955		New York City	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
123 Main St.		Teacher		High School		Married		Heart Disease		Natural	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF DEPARTURE FROM STATE		DATE OF RETURN TO STATE		DATE OF RE-ENTRY TO STATE	
1910		New York		1930		1950		1955		1955	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1955		New York City		1955		New York City		1955		New York City	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1955		New York City		1955		New York City		1955		New York City	

12716 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3, Film G-235 11/18/58.cac

Reg. Dist. No. 215

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10421 Montrose Ave., Parkside Apts.		d. STREET ADDRESS 10421 Montrose Ave., Parkside Apts. e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Irving LEAHY		4. DATE OF DEATH Month Day Year November 8 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-9-98
9. AGE (in years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer-lawyer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy - Law	
11. BIRTHPLACE (State or foreign country) Hartford, Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. LEAHY		14. MOTHER'S MAIDEN NAME Katharine (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1919 to 1950		16. SOCIAL SECURITY NO. (F) RADM Paul L Mathers, 9602 Rockville Pike	
17. INFORMANT (F) RADM Paul L Mathers, 9602 Rockville Pike		Address Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.1 Occlusion, right coronary artery DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary sclerosis, marked (c) stolting the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden Unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8 November 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-10-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, 7557 Wisc. Ave.,		24a. REC'D BY REGISTRAR DATE NOV 12 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
1934 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1934

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John J. McQuinn		Male		35		11-10-34		Washington, D.C.	
Residence		Occupation		Cause of Death		Manner of Death		Signature of Examiner	
Washington, D.C.		Engineer		Heart Disease		Natural		J. H. McQuinn	
Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Autopsy	
11-10-34		Washington, D.C.		11-10-34		11-10-34		11-10-34	
Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Examiner	
11-10-34		Washington, D.C.		Heart Disease		Natural		J. H. McQuinn	
Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Autopsy	
11-10-34		Washington, D.C.		11-10-34		11-10-34		11-10-34	

12717

CERTIFICATE OF DEATH

12709

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Airy-Rural RD#1 10X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged		d. STREET ADDRESS McKaig	
3. NAME OF DECEASED (Type or print) First Middle Last NANNIE C. LEASE		4. DATE OF DEATH Month Day Year NOV 30 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-7-74
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 11-7-74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY COLLEGE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM H. LEASE		14. MOTHER'S MAIDEN NAME ANNA M. McALISTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Austin R. Lease (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonitis RT Lung DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE (c) ARTEROSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 11-12-58 11-19-58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 492X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-21 , 19 57 , to 11-30 , 19 58 , that I last saw the deceased alive on 11-26 , 19 58 , and that death occurred at 9:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10128 CEDAR LANE Kensington, Md DATE SIGNED 11-30-58			
ACTUAL SIGNATURE Sarah E. Glover		M.D. 10128 CEDAR LANE Kensington, Md	
PHYSICIAN'S NAME (Type) Sarah E. Glover, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-3-58	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE DEC 2 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Thoma

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
12718 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

12710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>1 Yr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg</u>	
		d. STREET ADDRESS <u>1 Rural</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Clo</u> Last <u>Leckrone</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>5th</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 13-1880</u>
9. AGE (In years last birthday) <u>78 yrs.</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>22</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Brownsburg Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William T. Free</u>		14. MOTHER'S MAIDEN NAME <u>Sara E. Goudy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <u>Mrs Sara Jane Whittier. Gaithersburg. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PULMONARY EMBOLUS</u> (c) <u>Hypertensive Cardio Vascular</u> <u>Renal</u>		INTERVAL BETWEEN ONSET AND DEATH <u>FOUR HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8.10</u> 19 <u>57</u> , to <u>Nov. 5</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Oct. 24</u> 19 <u>58</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.		<u>Gaithersburg, Md.</u> <u>11.5.58</u>	
PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>		<u>Gaithersburg. Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-8-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GreenLawn</u>		22d. LOCATION (City, town, or county) (State) <u>Brownsburg. Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. DATE OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF NEXT OF KIN</p>	
<p>16. SIGNATURE OF CLERK</p>		<p>17. SIGNATURE OF JUDGE</p>		<p>18. SIGNATURE OF SHERIFF</p>		<p>19. SIGNATURE OF CORONER</p>		<p>20. SIGNATURE OF JURY</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12719
CERTIFICATE OF DEATH

12711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>184 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 15</u> <u>3401-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			d. STREET ADDRESS <u>3924 Boarman Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Herbert</u> Last <u>Levin</u>			4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1937</u>		9. AGE (In years last birthday) <u>21</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student (None)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Samuel Levin</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Silver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-34-5790</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcoma of right foot & pulmonary metastases</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>19 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>May 19</u> <u>1958</u> , to <u>November 19</u> <u>1958</u> , that I last saw the deceased alive on <u>November 19</u> <u>1958</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>James M. Marsh</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u>		DATE SIGNED <u>11/20/58</u>	
PHYSICIAN'S NAME (Type) <u>James M. Marsh, M.D.</u>		National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sharon T. Long</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levman & Bros Inc</u>		ADDRESS <u>1124 26</u>		24a. REC'D BY REGISTRAR <u>NOV 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

12720

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)				c. LENGTH OF STAY IN 1b 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				d. STREET ADDRESS 3801 Conn. Ave. NW, Wash., D.C.			
3. NAME OF DECEASED (Type or print) First John Middle (n) Last LEVINTOHL				4. DATE OF DEATH Month November Day 22 Year 1958			
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 March 1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY Barber		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Hoyman LEVINTOHL				14. MOTHER'S MAIDEN NAME Jenny STESER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I 578-246030		17. INFORMANT 3020 Rodman St., N.W., Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Carcinoma DUE TO (c) 25 Days							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 29 , 19 58 , to November 22 , 19 58 , that I last saw the deceased alive on November 22 , 19 58 , and that death occurred at 4:05 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A. Miale Jr.				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC			
DATE SIGNED 11-22-58							
PHYSICIAN'S NAME (Type) A. MIALE Jr., LT, MC, USN				Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-58		22c. NAME OF CEMETERY OR CREMATORY Adas Isreal Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Danzanski & Sons				ADDRESS Danzanski & Sons, 3501 14th St., NW, Wash., D.C.		24a. REC'D BY REGISTRAR NOV 26 '58	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1912

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
J. Edgar Hoover		Male		45		Jan 1, 1867		Washington, D.C.		Washington, D.C.		Heart Disease		Washington, D.C.		Jan 1, 1912		J. Edgar Hoover		J. Edgar Hoover	
Name of Informant		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Informant		Signature of Registrar	
J. Edgar Hoover		Male		45		Jan 1, 1867		Washington, D.C.		Washington, D.C.		Heart Disease		Washington, D.C.		Jan 1, 1912		J. Edgar Hoover		J. Edgar Hoover	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12614
CERTIFICATE OF DEATH

12713

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>WASH. SAN. AND HOSPITAL</u>		d. STREET ADDRESS <u>115 CROYDON COURT.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RALPH JACKSON LILLIBRIDGE</u>		4. DATE OF DEATH Month Day Year <u>NOV. 2 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 16, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER</u>	
11. BIRTHPLACE (State or foreign country) <u>IOVA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHAS. LILLIBRIDGE</u>		14. MOTHER'S MAIDEN NAME <u>MARY JACKSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>SPANISH-AMER.</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Mrs. Sarah B. Lillibridge, 115 Croydon Ct.</u>		Address <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>acute pulmonary edema.</u> DUE TO <u>Myocardial Infarction, Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>coronary occlusion.</u> DUE TO (c) <u>coronary atherosclerosis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 DAYS</u> <u>3-4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral and General atherosclerosis.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1958</u> to <u>NOV. 2, 1958</u> , that I last saw the deceased alive on <u>Nov. 2, 1958</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Danora A. Roberts</u>		ADDRESS (Street, city or town, state) <u>8907 GEORGIA AVE. SILVER SPRING, MD</u>	
DATE SIGNED <u>NOV. 2, 1958</u>			
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL 11/6/58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MUSCATINE, IOWA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

File No.

1. FULL NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
JAMES E. HARRIS		Male		45		White		1910		Baltimore, Md.		1955		Baltimore, Md.		10:00 AM		Heart Disease		Natural		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.	
16. FULL NAME OF DECEASED		17. SEX		18. AGE		19. RACE		20. DATE OF BIRTH		21. PLACE OF BIRTH		22. DATE OF DEATH		23. PLACE OF DEATH		24. TIME OF DEATH		25. CAUSE OF DEATH		26. MANNER OF DEATH		27. SIGNATURE OF PHYSICIAN		28. SIGNATURE OF REGISTRAR		29. SIGNATURE OF WITNESS		30. SIGNATURE OF DECEASED	
JAMES E. HARRIS		Male		45		White		1910		Baltimore, Md.		1955		Baltimore, Md.		10:00 AM		Heart Disease		Natural		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.	

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 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12721 CERTIFICATE OF DEATH

12714

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		d. STREET ADDRESS 1805 37th St., N. W. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HATTIE Middle BELLE Last LINDSAY		4. DATE OF DEATH Month November Day 21 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) school teacher (retired)		10b. KIND OF BUSINESS OR INDUSTRY Illinois	9. AGE (In years last birthday) yrs. 85
13. FATHER'S NAME Lewis F. Lindsay		14. MOTHER'S MAIDEN NAME Mary H. Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Kathryn H. Rawls, 1805 37th St., NW		Address Wash., D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arterio sclerosis - myocardial fibers DUE TO INTERVAL BETWEEN ONSET AND DEATH 24 hrs (c) Indeterminate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the Colon & Metastases			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August , 19 58 , to Nov 8 , 19 58 , that I last saw the deceased alive on Oct 29 , 19 58 , and that death occurred at 4:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew G. Prandoni		ADDRESS (Street, city or town, state) 1150 Conn. Ave. N.W. Wash. D.C.	
PHYSICIAN'S NAME (Type) Andrew G. Prandoni		DATE SIGNED 11/8/58	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 11-12-1958	22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	22d. LOCATION (City, town, or county) (State) Waukegan, Illinois
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley Sons, Washington, D.C.		24a. REC'D BY REGISTRAR DATE NOV 12 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

12722

CERTIFICATE OF DEATH

12715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>3159 Tennyson N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Christy</u> Last <u>Lipp</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12 1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing-Heating</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
13. FATHER'S NAME <u>Carrollis Lipp</u>				14. MOTHER'S MAIDEN NAME <u>P</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1917</u>				16. SOCIAL SECURITY NO. <u>577-48-2837</u>			
17. INFORMANT <u>Carl Lipp Jr.</u>				Address <u>Backroads Ind. 5906 Conaway Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>POSTERIOR MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombosis, Posterior Coronary Artery</u> DUE TO (c) <u>Coronary atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 29 1958</u> to <u>Nov 17 1958</u> that I last saw the deceased alive on <u>Nov. 17 1958</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Havell</u> M.D. <u>5516 Neb. Ave - DC 11-18-58</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Robert B. Havell M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. H. Jones Co 2901-14th St. N.W.</u> ADDRESS <u>Washington, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 20 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

12716

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 85 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Viola Last Lowery			4. DATE OF DEATH Month November Day 21 Year 19 58				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1923		9. AGE (In years last birthday) 35 yrs. 6 Months 18 Days 18 Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Quincy T. Lowery			14. MOTHER'S MAIDEN NAME Lena Stella Dean				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure due to Carcinoma of lung DUE TO 171 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary ca. of lung and/or secondary metastatic carcinoma of lung DUE TO Epidermoid carcinoma of cervix uteri (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from August 27, 19 58 to November 21, 19 58 , that I last saw the deceased alive on November 21, 19 58 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Marvin M. Romsdahl		M.D. The Clinical Center		ADDRESS (Street, city or town, state) The National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Marvin M. Romsdahl, M. D.		DATE SIGNED 11/21/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Pauls Episcopal			
22d. LOCATION (City, town, or county) Point of Rocks, Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland				
24a. REC'D BY REGISTRAR NOV 26 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Evans					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of _____

City of _____

State of New York

11-11-11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12724

CERTIFICATE OF DEATH

12717

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6820 Delaware Street				d. STREET ADDRESS 6820 Delaware Street			
3. NAME OF DECEASED (Type or print) First MORTIMER Middle C Last LYDDANE				4. DATE OF DEATH Month November Day 21 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1883	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 11 Days 19 Hours Min. 		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Thomas O Lyddane				14. MOTHER'S MAIDEN NAME Mary E. Sceior			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Clara T. Lyddane-wife-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute myocardial infarction (c) coronary artery disease						INTERVAL BETWEEN ONSET AND DEATH 1 hour 70 mins. 10-20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X Left lower lobe pneumonia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from Nov. 19 49 to Nov. 21, 19 58 , that I last saw the deceased alive on Nov. 21, 19 58 , and that death occurred at 8 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Sanford J Randall		M.D. 3636		ADDRESS (Street, city or town, state) 16 ST. N.W. D.C.		DATE SIGNED	
PHYSICIAN'S NAME (Type) SANFORD J. RANDALL M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/25/58	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE NOV 26 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

1917

1917

NAME OF DECEASED		DATE OF DEATH	
JAMES J. JONES		JANUARY 1, 1917	
AGE		SEX	
45		Male	
RACE		COLOR	
White		White	
BIRTH		PLACE OF BIRTH	
JANUARY 1, 1872		MASSACHUSETTS	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
DATE OF MARRIAGE		OCCUPATION	
JANUARY 1, 1900		Carpenter	
PREVIOUS DEATHS		CAUSE OF DEATH	
None		Heart Disease	
MANNER OF DEATH		PLACE OF DEATH	
Natural		Home	
CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
JAMES J. JONES		JAMES J. JONES	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 1, 1917		JANUARY 1, 1917	
WITNESSES		DOCTOR	
JAMES J. JONES		JAMES J. JONES	
DATE OF WITNESSES		DATE OF DOCTOR	
JANUARY 1, 1917		JANUARY 1, 1917	
LOCAL HEALTH OFFICER		STATE HEALTH OFFICER	
JAMES J. JONES		JAMES J. JONES	
DATE OF LOCAL HEALTH OFFICER		DATE OF STATE HEALTH OFFICER	
JANUARY 1, 1917		JANUARY 1, 1917	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12718

12725

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>—</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Marshall</u> Last <u>MAGRUDER</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 30, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Walter Marion Magruder</u>		14. MOTHER'S MAIDEN NAME <u>Clara Avalon Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>213-34-5144</u>	
17. INFORMANT <u>Mrs Daisy Magruder</u> Address <u>Brookeville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>200.1</u> DUE TO <u>Inanition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Lympho sarcoma</u> DUE TO (c) <u>5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Urinary Tract Infection</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 24</u> , 19 <u>58</u> , to <u>Nov.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Yates</u>		ADDRESS (Street, city or town, state) <u>Olney, Md.</u> DATE SIGNED <u>11-25-58</u>	
PHYSICIAN'S NAME (Type) <u>Richard A. YATES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV-28-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FOREST OAK</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROY W. BARBER</u> ADDRESS <u>GAITHERSBURG MD</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>DEC 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. RACE [Illegible]</p>	
<p>5. DATE OF BIRTH [Illegible]</p>		<p>6. PLACE OF BIRTH [Illegible]</p>	
<p>7. DATE OF DEATH [Illegible]</p>		<p>8. PLACE OF DEATH [Illegible]</p>	
<p>9. CAUSE OF DEATH [Illegible]</p>		<p>10. MANNER OF DEATH [Illegible]</p>	
<p>11. SIGNATURE OF DECEASED [Illegible]</p>		<p>12. SIGNATURE OF WITNESS [Illegible]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>14. SIGNATURE OF CORONER [Illegible]</p>	
<p>15. SIGNATURE OF JURY [Illegible]</p>		<p>16. SIGNATURE OF JUDGE [Illegible]</p>	
<p>17. SIGNATURE OF CLERK [Illegible]</p>		<p>18. SIGNATURE OF REGISTRAR [Illegible]</p>	
<p>19. SIGNATURE OF [Illegible] [Illegible]</p>		<p>20. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>21. SIGNATURE OF [Illegible] [Illegible]</p>		<p>22. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>23. SIGNATURE OF [Illegible] [Illegible]</p>		<p>24. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>25. SIGNATURE OF [Illegible] [Illegible]</p>		<p>26. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>27. SIGNATURE OF [Illegible] [Illegible]</p>		<p>28. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>29. SIGNATURE OF [Illegible] [Illegible]</p>		<p>30. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>31. SIGNATURE OF [Illegible] [Illegible]</p>		<p>32. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>33. SIGNATURE OF [Illegible] [Illegible]</p>		<p>34. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>35. SIGNATURE OF [Illegible] [Illegible]</p>		<p>36. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>37. SIGNATURE OF [Illegible] [Illegible]</p>		<p>38. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>39. SIGNATURE OF [Illegible] [Illegible]</p>		<p>40. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>41. SIGNATURE OF [Illegible] [Illegible]</p>		<p>42. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>43. SIGNATURE OF [Illegible] [Illegible]</p>		<p>44. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>45. SIGNATURE OF [Illegible] [Illegible]</p>		<p>46. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>47. SIGNATURE OF [Illegible] [Illegible]</p>		<p>48. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>49. SIGNATURE OF [Illegible] [Illegible]</p>		<p>50. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>51. SIGNATURE OF [Illegible] [Illegible]</p>		<p>52. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>53. SIGNATURE OF [Illegible] [Illegible]</p>		<p>54. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>55. SIGNATURE OF [Illegible] [Illegible]</p>		<p>56. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>57. SIGNATURE OF [Illegible] [Illegible]</p>		<p>58. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>59. SIGNATURE OF [Illegible] [Illegible]</p>		<p>60. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>61. SIGNATURE OF [Illegible] [Illegible]</p>		<p>62. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>63. SIGNATURE OF [Illegible] [Illegible]</p>		<p>64. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>65. SIGNATURE OF [Illegible] [Illegible]</p>		<p>66. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>67. SIGNATURE OF [Illegible] [Illegible]</p>		<p>68. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>69. SIGNATURE OF [Illegible] [Illegible]</p>		<p>70. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>71. SIGNATURE OF [Illegible] [Illegible]</p>		<p>72. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>73. SIGNATURE OF [Illegible] [Illegible]</p>		<p>74. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>75. SIGNATURE OF [Illegible] [Illegible]</p>		<p>76. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>77. SIGNATURE OF [Illegible] [Illegible]</p>		<p>78. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>79. SIGNATURE OF [Illegible] [Illegible]</p>		<p>80. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>81. SIGNATURE OF [Illegible] [Illegible]</p>		<p>82. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>83. SIGNATURE OF [Illegible] [Illegible]</p>		<p>84. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>85. SIGNATURE OF [Illegible] [Illegible]</p>		<p>86. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>87. SIGNATURE OF [Illegible] [Illegible]</p>		<p>88. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>89. SIGNATURE OF [Illegible] [Illegible]</p>		<p>90. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>91. SIGNATURE OF [Illegible] [Illegible]</p>		<p>92. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>93. SIGNATURE OF [Illegible] [Illegible]</p>		<p>94. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>95. SIGNATURE OF [Illegible] [Illegible]</p>		<p>96. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>97. SIGNATURE OF [Illegible] [Illegible]</p>		<p>98. SIGNATURE OF [Illegible] [Illegible]</p>	
<p>99. SIGNATURE OF [Illegible] [Illegible]</p>		<p>100. SIGNATURE OF [Illegible] [Illegible]</p>	

101

12726

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN lb <u>205 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>138 Summit Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>Ann</u> Last <u>Markus</u>				4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 18, 1934</u>	
9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Albert E. Manners</u>				14. MOTHER'S MAIDEN NAME <u>Verna Bender</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unavailable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> <u>173X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchiopneumonia</u> DUE TO (c) <u>Metastatic Chorion carcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>7 days</u> <u>2 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>April 21</u> , 19 <u>58</u> , to <u>November 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>November 12</u> , 19 <u>58</u> , and that death occurred at <u>12:55 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11-12-58</u> The National Institutes of Health <u>Bethesda 14, Maryland</u>							
ACTUAL SIGNATURE <u>Donald A. Kellogg</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Donald A. Kellogg, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Trans</u>		22b. DATE THEREOF <u>11/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Northampton Mem. Shrine</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 13 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12727

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arkansas</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anette</u> Middle <u>(none)</u> Last <u>McClain</u>				4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 19, 1951</u>	
9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>James W. McClain</u>				14. MOTHER'S MAIDEN NAME <u>Juanita Orender</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right ventricular heart failure</u> <u>754.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary hypertension</u> DUE TO (c) <u>Ventricular septal defect, Atrial septal defect</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 2, 1958</u> to <u>November 12, 1958</u> , that I last saw the deceased alive on <u>November 12, 1958</u> , and that death occurred at <u>10:26 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William P. Cornell</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/13/58</u>			
PHYSICIAN'S NAME (Type) <u>William P. Cornell, M. D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>11/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Benton, Arkansas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>William P. Cornell</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12731

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

12732

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

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Robert P. Purness-Bethesda, Maryland

DATE OF DEATH 12/23/58

Bethesda, Maryland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 18&21 Film 236 11-20-58
12728 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. STREET ADDRESS <u>4308 Ambler Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Naomi</u> Middle <u>A.</u> Last <u>McIlroy</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/14/76</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Gutschall</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Kern</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John E. McIlroy</u>		Address <u>4308 Ambler Dr. Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive subarachnoid hemorrhage</u> <u>902.7</u> - Due to - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Old subdural hemorrhage</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from roof. head</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4</u> o. m. <u>p.m.</u> <u>11-4 1958</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Roof</u>		20f. (City or town) (County) (State) <u>Bethesda Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>11-4-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Riverview</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingdon, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumfrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

1978

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
1978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE
TIME

PLACE CHARGE
IN BOX

DATE OF DEATH
TIME

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IN BOX

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PLACE OF DEATH
IN BOX

Robert A. Pumpnery-Belknap, Maryland
11/1/58
Riverview
Baltimore, Pennsylvania

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12729 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7809 Stratford Rd</u>			d. STREET ADDRESS <u>7809 Stratford Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Oscar</u>			4. DATE OF DEATH <u>Nov 26</u> 19 <u>58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1884</u>		9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>roofing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>Charles Mc Intosh</u>			14. MOTHER'S MAIDEN NAME <u>Anne Moulder</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>100-1-10000</u>		17. INFORMANT <u>B. Sears - Son of Deceased</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>gave rise to immediate cause</u> (c) <u>stating the underlying cause lost.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-26-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR <u>NOV 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12730

CERTIFICATE OF DEATH

12723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 379 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lady Middle Vera Last McInturff				4. DATE OF DEATH Month November Day 26 Year 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1904	
9. AGE (In years last birthday) 54 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Wright		14. MOTHER'S MAIDEN NAME Grace Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding gastric ulcers, 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute myelogenous leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 yr.						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 12, 1957 to November 26, 1958 , that I last saw the deceased alive on November 26, 1958 , and that death occurred at 9:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold R. Silberman M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-26-58			
PHYSICIAN'S NAME (Type) Harold R. Silberman, M. D.				ADDRESS National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Beverly Mountcastle ADDRESS Cunningham Funeral Home Alexandria, Va.				24a. REC'D BY REGISTRAR DATE DEC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

12615 Maryland State Department of Health—BALTIMORE, 18
12724
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>West Virginia</u> b. COUNTY <u>Wood</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakona Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkersburg, West Virginia</u>	
c. LENGTH OF STAY IN 1b <u>1 week</u>		47 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>517 Albany Avenue Oak Haven Conv. Home</u>		d. STREET ADDRESS <u>1400 7th Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MATTIE FRANCIS MEAD</u>		4. DATE OF DEATH <u>November 7, 1958</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 31, 1867</u>	
9. AGE (In years lost birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bakery Business (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTH PLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Shingleton</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>170 X</u>	
17. INFORMANT <u>Mrs. Mildred Grogg</u> Address <u>9922 Ga. Ave. S.E. Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction partial</u> <u>170 X</u> DUE TO <u>Cholecystitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lower of the L breast</u> (c) <u>170 X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>20</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/19, 1958</u> , to <u>11/71</u> , 1958 that I last saw the deceased alive on <u>11/6</u> , 1958, and that death occurred at <u>500 Underwood St NW</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Arthur S. Kraus</u>	
ACTUAL SIGNATURE <u>Chas. H. Wolcott IV</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Chas. H. Wolcott IV</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 10, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkersburg, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Arthur Walters</u> ADDRESS <u>254 Carroll Rd NW</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED JAMES EARL RAY		SEX Male		RACE White	
DATE OF BIRTH May 19, 1928		PLACE OF BIRTH Jackson, Tennessee		COUNTY OF BIRTH Shelby	
DATE OF DEATH April 4, 1968		PLACE OF DEATH Memphis, Tennessee		COUNTY OF DEATH Shelby	
TIME OF DEATH 2:01 PM		CAUSE OF DEATH Gunshot wound		MANNER OF DEATH Homicide	
I, the undersigned, being a duly qualified medical examiner, hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the above named person.		I, the undersigned, being a duly qualified medical examiner, hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the above named person.		I, the undersigned, being a duly qualified medical examiner, hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the above named person.	
SIGNATURE OF MEDICAL EXAMINER [Signature]		SIGNATURE OF MEDICAL EXAMINER [Signature]		SIGNATURE OF MEDICAL EXAMINER [Signature]	
DATE OF CERTIFICATE April 10, 1968		DATE OF CERTIFICATE April 10, 1968		DATE OF CERTIFICATE April 10, 1968	
PLACE OF DEATH Memphis, Tennessee		PLACE OF DEATH Memphis, Tennessee		PLACE OF DEATH Memphis, Tennessee	
COUNTY OF DEATH Shelby		COUNTY OF DEATH Shelby		COUNTY OF DEATH Shelby	
STATE OF DEATH Tennessee		STATE OF DEATH Tennessee		STATE OF DEATH Tennessee	
CITY OF DEATH Memphis		CITY OF DEATH Memphis		CITY OF DEATH Memphis	
ZIP CODE 38103		ZIP CODE 38103		ZIP CODE 38103	
I, the undersigned, being a duly qualified medical examiner, hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the above named person.		I, the undersigned, being a duly qualified medical examiner, hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the above named person.		I, the undersigned, being a duly qualified medical examiner, hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the above named person.	
SIGNATURE OF MEDICAL EXAMINER [Signature]		SIGNATURE OF MEDICAL EXAMINER [Signature]		SIGNATURE OF MEDICAL EXAMINER [Signature]	
DATE OF CERTIFICATE April 10, 1968		DATE OF CERTIFICATE April 10, 1968		DATE OF CERTIFICATE April 10, 1968	
PLACE OF DEATH Memphis, Tennessee		PLACE OF DEATH Memphis, Tennessee		PLACE OF DEATH Memphis, Tennessee	
COUNTY OF DEATH Shelby		COUNTY OF DEATH Shelby		COUNTY OF DEATH Shelby	
STATE OF DEATH Tennessee		STATE OF DEATH Tennessee		STATE OF DEATH Tennessee	
CITY OF DEATH Memphis		CITY OF DEATH Memphis		CITY OF DEATH Memphis	
ZIP CODE 38103		ZIP CODE 38103		ZIP CODE 38103	

JAMES EARL RAY

10-68

This is a true and correct statement of the facts and circumstances surrounding the death of the above named person. I, the undersigned, being a duly qualified medical examiner, hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the above named person.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12731

CERTIFICATE OF DEATH

Reg. Dist. No.

12725

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 607 Midland Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) 607 Midland Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Eugene Last Mercogliano		4. DATE OF DEATH Month November Day 30 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1920
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Chief Technical Program		10b. KIND OF BUSINESS OR INDUSTRY Internal Revenue	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Angelo Mercogliano		14. MOTHER'S MAIDEN NAME Lillian Ricci	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (Coast Guard)		16. SOCIAL SECURITY NO. 579-09-1331	
17. INFORMANT Mrs. Carol J. Mercogliano - Same #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Retropharyngeal Carcinoma. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Staphylococcus Septicemia (Healed)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 19 Day 19 Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1958 to 30 Nov 1958 , that I last saw the deceased alive on 29 Nov 1958 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas P. Fogarty M.D.			
PHYSICIAN'S NAME (Type) Thomas P. Fogarty -- 1036 University Blyd E. Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/1958	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. - 2901 14th St., N.W.		24a. REC'D BY REGISTRAR DEC 3 '58	
24b. REGISTRAR'S SIGNATURE John S. Hines			

12732

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 hrs.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 5615 McKinley Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Carel Hasson MILLER				4. DATE OF DEATH Month Day Year November 25 19 58			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-26-99	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Minn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John HASSON				14. MOTHER'S MAIDEN NAME Josephine NORLING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. None		17. INFORMANT (H) Francis G. Miller, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction, myocardium 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes, mellitus X and (c) Hypothyroidism							INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 32 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 25, 19 58 , to November 25, 19 58 , that I last saw the deceased alive on November 25, 19 58 , and that death occurred at 1:55P M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC			
DATE SIGNED 11-25-58							
PHYSICIAN'S NAME (Type) J. M. YOUNG, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-28-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>				ADDRESS R.A. Humphrey Funeral Home, 7557 Wisc. Ave., Bethesda		24a. REC'D BY REGISTRAR NOV 28 '58	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film G235 11-7-58 et
12733
CERTIFICATE OF DEATH

12728

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>H</u> Last <u>MILLMAN</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 6 1986</u> AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Letter Carrier</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Myer MILLMAN</u>				14. MOTHER'S MAIDEN NAME <u>Rachael UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>4000 mass ave</u>		17. INFORMANT <u>MR. Aaron Millman</u> Address <u>Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Coronary failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>11/1</u> , 19 <u>58</u> , to <u>11/1</u> , 19 <u>58</u> that I last saw the deceased alive on <u>11/1</u> , 19 <u>58</u> , and that death occurred at <u>3:10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Donald P. Elman</u> M.D.							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 2, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. D. Wangansky & Son</u> ADDRESS <u>3501-14 St. N.W. W.D.C.</u>				24a. REC'D BY REGISTRAR <u>NOV 5 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

12734 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3, 13 & 17 Film G-236 12/4/58.cac.

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>		e. STREET ADDRESS <u>Md. R - 124</u>	
3. NAME OF DECEASED (Type or print) <u>Forrest Tuttle</u> First <u>Minor</u> Middle <u>S</u> Last <u>MINOR</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/1903</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant Modelbas</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elbert Minor</u>		14. MOTHER'S MAIDEN NAME <u>May Breeding</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u> , <u>Dec 8-42</u>		16. SOCIAL SECURITY NO. <u>8-42</u>	
17. INFORMANT <u>Minor</u>		Address <u>Gertrude Minor (wife)</u> <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tetraethyl Pyrophosphate Poisoning</u> <u>971.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>stating the underlying cause last.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>4 hr.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Taken 4 oz. Kilmit P at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-19-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE SIGNED <u>11/15/58</u>	

MEDICAL CERTIFICATION

2

12329

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
12329 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEATH REGISTRY

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Examiner	
10. Signature of Coroner		11. Signature of Physician		12. Signature of Medical Examiner	
13. Signature of Registrar		14. Signature of Clerk		15. Signature of Nurse	
16. Signature of Chaplain		17. Signature of Undertaker		18. Signature of Burial Place	
19. Signature of Funeral Home		20. Signature of Cemetery		21. Signature of Interment	
22. Signature of Burial		23. Signature of Burial		24. Signature of Burial	
25. Signature of Burial		26. Signature of Burial		27. Signature of Burial	
28. Signature of Burial		29. Signature of Burial		30. Signature of Burial	
31. Signature of Burial		32. Signature of Burial		33. Signature of Burial	
34. Signature of Burial		35. Signature of Burial		36. Signature of Burial	
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52. Signature of Burial		53. Signature of Burial		54. Signature of Burial	
55. Signature of Burial		56. Signature of Burial		57. Signature of Burial	
58. Signature of Burial		59. Signature of Burial		60. Signature of Burial	
61. Signature of Burial		62. Signature of Burial		63. Signature of Burial	
64. Signature of Burial		65. Signature of Burial		66. Signature of Burial	
67. Signature of Burial		68. Signature of Burial		69. Signature of Burial	
70. Signature of Burial		71. Signature of Burial		72. Signature of Burial	
73. Signature of Burial		74. Signature of Burial		75. Signature of Burial	
76. Signature of Burial		77. Signature of Burial		78. Signature of Burial	
79. Signature of Burial		80. Signature of Burial		81. Signature of Burial	
82. Signature of Burial		83. Signature of Burial		84. Signature of Burial	
85. Signature of Burial		86. Signature of Burial		87. Signature of Burial	
88. Signature of Burial		89. Signature of Burial		90. Signature of Burial	
91. Signature of Burial		92. Signature of Burial		93. Signature of Burial	
94. Signature of Burial		95. Signature of Burial		96. Signature of Burial	
97. Signature of Burial		98. Signature of Burial		99. Signature of Burial	
100. Signature of Burial		101. Signature of Burial		102. Signature of Burial	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12616 **CERTIFICATE OF DEATH**

12730

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN <u>12 hours</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u> d. STREET ADDRESS <u>5939 2nd Street N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EDITH E. MOORE</u>		4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1958</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 8, 1889</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> 11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Gladden Ridgeway</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Hospital Record</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Nephritis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Indefinite</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct. 29, 1958</u> , to <u>Nov. 25, 1958</u> , that I last saw the deceased alive on <u>Nov. 25, 1958</u> , and that death occurred at <u>7:30 P.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6911 5th St. N.W.</u> DATE SIGNED <u> </u> ACTUAL SIGNATURE <u>A. B. Little</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>A. B. LITTLE MD</u> <u>Wash. D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>4th Memorial</u>			
22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Finkel Funeral Home</u> ADDRESS <u>510 C St. N.E.</u> <u>Washington D.C.</u> <u>#268</u>					
24a. REC'D BY REGISTRAR <u> </u> DATE <u>Nov 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

12735

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb 6 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6302 Hollins Dr.		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Samuel Edward Morthy		4. DATE OF DEATH Nov. 14, 1958	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/1910
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY N.C. Eastman	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11/17/58	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 11.18.58	22c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. Anderson		24a. REC'D BY REGISTRAR NOV 21 '58	
		24b. REGISTRAR'S SIGNATURE William S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
DEATH

1873

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1873

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12736 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12732

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN TB <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>103 Hutton St</u>				d. STREET ADDRESS <u>103 Hutton St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Moritz</u> Middle <u>Ludwig</u> Last <u>Mueller</u>				4. DATE OF DEATH Month <u>nov</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-30-92</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mathematic Eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury City Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Richard Mueller</u>				14. MOTHER'S MAIDEN NAME <u>Katia Walker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Cecilia Mueller (wife)</u>		Address <u>Stm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-1-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairlincoln</u>		22d. LOCATION (City, town, or county) <u>Bladensburg</u>	(State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett C. Fenton Gaithersburg Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

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PLACE OF REINTERMENT

12737

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 4 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park d. STREET ADDRESS 124 Anderson Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Blain Allen MUMBY				4. DATE OF DEATH Month Day Year November 4 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-31-58	
9. AGE (In years last birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald C. MUMBY				14. MOTHER'S MAIDEN NAME Patricia ALLEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Donald C. Mumby, 124 Anderson Ct., Lex.Pk.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline membrane disease DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 31, 1958 , to November 4, 1958 , that I last saw the deceased alive on November 4, 1958 , and that death occurred at 6:40PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NNMC 11-5-58							
ACTUAL SIGNATURE H. L. Walton		M.D. U. S. Naval Hospital, NNMC					
PHYSICIAN'S NAME (Type) H. L. WALTON, LT, MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR NOV 7 '58	
23. FUNERAL HOME R. A. Pumphrey Funeral Home, 7557 Wisc. Ave.				24b. REGISTRAR'S SIGNATURE Arthur S. Kirsch			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Item 7 FilmG236 12-4-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b Olney d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. Gen. Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown d. STREET ADDRESS RFD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EVA First H. Middle NEEL Last		4. DATE OF DEATH Month November Day 25 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1893
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 3 Days 10	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10b. KIND OF BUSINESS OR INDUSTRY Groceries	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Edwin S. Houck	
14. MOTHER'S MAIDEN NAME Susan B. Hammitt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 579-24-4724		17. INFORMANT Rodney M. Thompson-Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO (b) Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Hypertension DUE TO (c) Old Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1957 , 19 11-25 , 19 58 , that I last saw the deceased alive on 11-25 , 19 58 , and that death occurred at 2:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. I. Leal		DATE SIGNED 11-25-58	
PHYSICIAN'S NAME (Type) L. I. Leal		ADDRESS 108 N. Frederick Ave., Gaithersburg, Maryland	
22a. BURIAL, CREMATION, REBURY (Specify) Burial	22b. DATE THEREOF 11/29/58	22c. NAME OF CEMETERY OR CREMATORY Neelsville	22d. LOCATION (City, town, or county) (State) Neelsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE NOV 28 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thrall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Education		Date of Birth		Date of Death		Place of Birth		Place of Death		Cause of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant		Date of Report	
Robert A. Humphrey-Bethesda, Md.		61		Male		White		White		Roman Catholic		Married		Physician		High School		November 23, 1933		November 23, 1933		Bethesda, Md.		Bethesda, Md.		Heart Disease		11:30 AM		J. I. Lenz		J. I. Lenz		J. I. Lenz		November 23, 1933	
108 N. Frederick Ave., Gaithersburg, Maryland		61		Male		White		White		Roman Catholic		Married		Physician		High School		November 23, 1933		November 23, 1933		Bethesda, Md.		Bethesda, Md.		Heart Disease		11:30 AM		J. I. Lenz		J. I. Lenz		J. I. Lenz		November 23, 1933	
108 N. Frederick Ave., Gaithersburg, Maryland		61		Male		White		White		Roman Catholic		Married		Physician		High School		November 23, 1933		November 23, 1933		Bethesda, Md.		Bethesda, Md.		Heart Disease		11:30 AM		J. I. Lenz		J. I. Lenz		J. I. Lenz		November 23, 1933	
108 N. Frederick Ave., Gaithersburg, Maryland		61		Male		White		White		Roman Catholic		Married		Physician		High School		November 23, 1933		November 23, 1933		Bethesda, Md.		Bethesda, Md.		Heart Disease		11:30 AM		J. I. Lenz		J. I. Lenz		J. I. Lenz		November 23, 1933	

12739

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Minnesota b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 71 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Minneapolis 60X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		d. STREET ADDRESS 1937 County Road "H"		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leonard Alfred NELSON		4. DATE OF DEATH Month November Day 27 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-30-40	9. AGE (In years last birthday) 18 yrs.	IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Minnesota	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Richard T. NELSON		14. MOTHER'S MAIDEN NAME Ester VERHALST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 713-58 toll-27-58 475 44 3066		17. INFORMANT (Father) Richard T. NELSON (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) glioblastoma multiforme DUE TO 1939 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 1/2 mos.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Minneapolis	(County) Minn. (State)
21. I certify that I attended the deceased from 26 September, 1958 , to 27 November, 1958 , that I last saw the deceased alive on 27 November, 1958 , and that death occurred at 8:40 P M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Matthew W. Wood MD		ADDRESS (Street, city or town, state) U.S. Naval Hospital, NNMC, Bethesda Md			
PHYSICIAN'S NAME (Type) Matthew W. WOOD LCDR MC USN		DATE SIGNED 11-28-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-2-58	22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial	22d. LOCATION (City, town, or county) (State) Minneapolis Minn.		
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home		ADDRESS 4748 Wisconsin Ave. Wash D.C.		24a. REC'D BY REGISTRAR DEC 2 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Kruze

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BATHING ORG TO

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

12736

Reg. Dist. No.

12740

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase, Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Margaret A O'Connor</i>				4. DATE OF DEATH Month Day Year <i>Nov. 30 1958</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/25/1904</i>	
9. AGE (In years last birthday) <i>54</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Phoenix Arizona</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>				13. FATHER'S NAME <i>Albert Sidney Arthur</i>			
14. MOTHER'S MAIDEN NAME <i>Ruth Sullivan</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>Unknown</i>				17. INFORMANT <i>Francis O'Connor (Husband)</i> Address <i>3417 Turner Lane</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Natural Cause</i> <i>153.8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of Large Intestine</i> DUE TO (c) <i>Carcinoma of Large Intestine</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 MONTH</i> <i>6 MONTHS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Jan</i> , 1958, to <i>Nov</i> , 1958, that I last saw the deceased alive on <i>Nov. 29</i> , 1958, and that death occurred at <i>4:10 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Leo I Donovan M.D.</i>				ADDRESS (Street, city or town, state) <i>1016 GERRY TOWN RD</i> DATE SIGNED <i>11/30/58</i>			
PHYSICIAN'S NAME (Type) <i>LEO I DONOVAN M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/3/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please receive carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

FULL NAME Robert A. Humphrey-Bethesda, Md.		SEX Male		AGE 13 1/2		OCCUPATION Mr. Oliver		RESIDENCE Washington, D. C.	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH 1920		PLACE OF DEATH Bethesda, Md.		DATE OF DEATH 1934		PLACE OF INTERMENT Washington, D. C.	
CAUSE OF DEATH (To be filled by physician)		MANNER OF DEATH (To be filled by physician)		MEDICAL HISTORY (To be filled by physician)		SURGICAL HISTORY (To be filled by physician)		PREVIOUS ILLNESS (To be filled by physician)	
SIGNATURE OF PHYSICIAN (To be filled by physician)		SIGNATURE OF DEATH REGISTRAR (To be filled by registrar)		SIGNATURE OF WITNESS (To be filled by witness)		SIGNATURE OF WITNESS (To be filled by witness)		SIGNATURE OF WITNESS (To be filled by witness)	

12741

CERTIFICATE OF DEATH

12737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
c. LENGTH OF STAY IN 1b 50 years				d. STREET ADDRESS 4420 Ridge Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4420 Ridge Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EUGENE Middle H Last O'NEAL				4. DATE OF DEATH Month Nov. Day 7 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1872	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 6 Days 15		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Engineer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Hillary O'Neal				14. MOTHER'S MAIDEN NAME Elizabeth Relay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 578-07-5302			
17. INFORMANT Mrs. Hazel R Howell-daughter-same as 2d				Address			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO Coronary Heart Disease (c) Coronary Heart Disease INTERVAL BETWEEN ONSET AND DEATH 30 days 8 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 19 54 , to Nov 19 58 , that I last saw the deceased alive on Nov 7 19 58 , and that death occurred at 6:50 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8016 Greentree Rd DATE SIGNED 11/1/58							
ACTUAL SIGNATURE Leo I Donovan M.D.							
PHYSICIAN'S NAME (Type) LEO I DONOVAN M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/58		22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR NOV 12 '58	
24b. REGISTRAR'S SIGNATURE Arthur E. Jones							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH April 14, 1900		5. PLACE OF BIRTH St. Louis, Mo.	
6. OCCUPATION Minister		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 160	
11. DATE OF DEATH April 4, 1968		12. TIME OF DEATH 10:15 AM		13. PLACE OF DEATH St. Louis, Mo.		14. CAUSE OF DEATH Suicide		15. MANNER OF DEATH Homicide	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS James Earl Ray		18. SIGNATURE OF DECEASED James Earl Ray		19. SIGNATURE OF WITNESS James Earl Ray		20. SIGNATURE OF DECEASED James Earl Ray	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF WITNESS James Earl Ray		23. SIGNATURE OF DECEASED James Earl Ray		24. SIGNATURE OF WITNESS James Earl Ray		25. SIGNATURE OF DECEASED James Earl Ray	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF WITNESS James Earl Ray		28. SIGNATURE OF DECEASED James Earl Ray		29. SIGNATURE OF WITNESS James Earl Ray		30. SIGNATURE OF DECEASED James Earl Ray	
31. SIGNATURE OF DECEASED James Earl Ray		32. SIGNATURE OF WITNESS James Earl Ray		33. SIGNATURE OF DECEASED James Earl Ray		34. SIGNATURE OF WITNESS James Earl Ray		35. SIGNATURE OF DECEASED James Earl Ray	
36. SIGNATURE OF DECEASED James Earl Ray		37. SIGNATURE OF WITNESS James Earl Ray		38. SIGNATURE OF DECEASED James Earl Ray		39. SIGNATURE OF WITNESS James Earl Ray		40. SIGNATURE OF DECEASED James Earl Ray	
41. SIGNATURE OF DECEASED James Earl Ray		42. SIGNATURE OF WITNESS James Earl Ray		43. SIGNATURE OF DECEASED James Earl Ray		44. SIGNATURE OF WITNESS James Earl Ray		45. SIGNATURE OF DECEASED James Earl Ray	
46. SIGNATURE OF DECEASED James Earl Ray		47. SIGNATURE OF WITNESS James Earl Ray		48. SIGNATURE OF DECEASED James Earl Ray		49. SIGNATURE OF WITNESS James Earl Ray		50. SIGNATURE OF DECEASED James Earl Ray	
51. SIGNATURE OF DECEASED James Earl Ray		52. SIGNATURE OF WITNESS James Earl Ray		53. SIGNATURE OF DECEASED James Earl Ray		54. SIGNATURE OF WITNESS James Earl Ray		55. SIGNATURE OF DECEASED James Earl Ray	
56. SIGNATURE OF DECEASED James Earl Ray		57. SIGNATURE OF WITNESS James Earl Ray		58. SIGNATURE OF DECEASED James Earl Ray		59. SIGNATURE OF WITNESS James Earl Ray		60. SIGNATURE OF DECEASED James Earl Ray	
61. SIGNATURE OF DECEASED James Earl Ray		62. SIGNATURE OF WITNESS James Earl Ray		63. SIGNATURE OF DECEASED James Earl Ray		64. SIGNATURE OF WITNESS James Earl Ray		65. SIGNATURE OF DECEASED James Earl Ray	
66. SIGNATURE OF DECEASED James Earl Ray		67. SIGNATURE OF WITNESS James Earl Ray		68. SIGNATURE OF DECEASED James Earl Ray		69. SIGNATURE OF WITNESS James Earl Ray		70. SIGNATURE OF DECEASED James Earl Ray	
71. SIGNATURE OF DECEASED James Earl Ray		72. SIGNATURE OF WITNESS James Earl Ray		73. SIGNATURE OF DECEASED James Earl Ray		74. SIGNATURE OF WITNESS James Earl Ray		75. SIGNATURE OF DECEASED James Earl Ray	
76. SIGNATURE OF DECEASED James Earl Ray		77. SIGNATURE OF WITNESS James Earl Ray		78. SIGNATURE OF DECEASED James Earl Ray		79. SIGNATURE OF WITNESS James Earl Ray		80. SIGNATURE OF DECEASED James Earl Ray	
81. SIGNATURE OF DECEASED James Earl Ray		82. SIGNATURE OF WITNESS James Earl Ray		83. SIGNATURE OF DECEASED James Earl Ray		84. SIGNATURE OF WITNESS James Earl Ray		85. SIGNATURE OF DECEASED James Earl Ray	
86. SIGNATURE OF DECEASED James Earl Ray		87. SIGNATURE OF WITNESS James Earl Ray		88. SIGNATURE OF DECEASED James Earl Ray		89. SIGNATURE OF WITNESS James Earl Ray		90. SIGNATURE OF DECEASED James Earl Ray	
91. SIGNATURE OF DECEASED James Earl Ray		92. SIGNATURE OF WITNESS James Earl Ray		93. SIGNATURE OF DECEASED James Earl Ray		94. SIGNATURE OF WITNESS James Earl Ray		95. SIGNATURE OF DECEASED James Earl Ray	
96. SIGNATURE OF DECEASED James Earl Ray		97. SIGNATURE OF WITNESS James Earl Ray		98. SIGNATURE OF DECEASED James Earl Ray		99. SIGNATURE OF WITNESS James Earl Ray		100. SIGNATURE OF DECEASED James Earl Ray	

12742

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE D.C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rasmor San. & Hosp.				d. STREET ADDRESS 1115 Chesapeake St., N.W.			
3. NAME OF DECEASED (Type or print) LOTTA HAZELLA PARKS				4. DATE OF DEATH Nov. 1st, 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct., 21, 1870	9. AGE (In years last birthday) 88 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel J. Burrows				14. MOTHER'S MAIDEN NAME Mariette A. Sheckells			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMATION Address 5605 Chesterbrook Rd., Sterling A. Parks, Springfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 561.4 DUE TO Cerebral Distortion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abdominal Hernia DUE TO (c) Abdominal Hernia						INTERVAL BETWEEN ONSET AND DEATH 1 year 1 1/2 years 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Atherosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1, 1946 , to Nov 1, 1958 , that I last saw the deceased alive on 11-1-58 , and that death occurred at 11:55 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE P. P. Andrews M.D.				ADDRESS (Street, city or town, state) 4201 Fennell St. N.W. Wash. D.C. 20015-2-58			
PHYSICIAN'S NAME (Type) P. P. ANDREWS M.D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home, Wash. D.C.				24a. REC'D BY REGISTRAR DATE NOV 5 '58		24b. REGISTRAR'S SIGNATURE Charles S. Hance	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12739

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2307 FOREST GLEN ROAD</u>		d. STREET ADDRESS <u>2307 FOREST GLEN ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELMER</u> Middle <u>ERMON</u> Last <u>PARSONS, SR.</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/3/83</u>
9. AGE (In years last birthday) <u>76 5</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automobile Mechanic (retired) Stanley Horner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>SEWEL ERNEST PARSONS</u>		14. MOTHER'S MAIDEN NAME <u>MARY HANLIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-20-1908</u>	
17. INFORMANT <u>Mr. Elmer E. Parsons, Jr.</u>		Address <u>2307 Forest Glen Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Hypostatic pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Larynx with Metastasis</u> DUE TO (c) <u>Pulmonary Emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-yr</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 19, 1957</u> to <u>November 23, 1958</u> , that I last saw the deceased alive on <u>November 23, 1958</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7600 Carroll Ave.; Takoma Park, Md.</u> DATE SIGNED <u>Nov 23, 1958</u>			
ACTUAL SIGNATURE <u>Elmer W. Lorenz, M.D.</u>		DATE SIGNED <u>Nov 23, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Elmer W. Lorenz, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Marshall Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Marshall, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u> <u>Raymond D. Zucka</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12744

CERTIFICATE OF DEATH

12740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 14 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Oliver Middle A. Last Patterson				4. DATE OF DEATH Month November Day 28 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/14/64	
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months 12 Days 18 Hours 12 Min.		IF UNDER 24 HRS. Months 12 Days 18 Hours 12 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME William Patterson				14. MOTHER'S MAIDEN NAME Clarissa Hartrift			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Records		Address Olney, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Insulin Shock DUE TO Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Prostatic Ca 2 yrs. Metast. (b) Prostatic Ca 2 yrs. Metast. (c) Prostatic Ca 2 yrs. Metast.							INTERVAL BETWEEN ONSET AND DEATH 12 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JUNE , 1954, to 28 Nov , 1958, that I last saw the deceased alive on 27 Nov , 1958, and that death occurred at 6:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. B. Ziegler M.D.				ADDRESS (Street, city or town, state) Olney, Md			
PHYSICIAN'S NAME (Type) J. B. Ziegler M.D.				DATE SIGNED 28 Nov 58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/1/58		22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR SEC 1 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12710

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of health officer	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of cremation		19. Signature of other disposition		20. Signature of other disposition	
21. Signature of other disposition		22. Signature of other disposition		23. Signature of other disposition		24. Signature of other disposition	
25. Signature of other disposition		26. Signature of other disposition		27. Signature of other disposition		28. Signature of other disposition	
29. Signature of other disposition		30. Signature of other disposition		31. Signature of other disposition		32. Signature of other disposition	
33. Signature of other disposition		34. Signature of other disposition		35. Signature of other disposition		36. Signature of other disposition	
37. Signature of other disposition		38. Signature of other disposition		39. Signature of other disposition		40. Signature of other disposition	
41. Signature of other disposition		42. Signature of other disposition		43. Signature of other disposition		44. Signature of other disposition	
45. Signature of other disposition		46. Signature of other disposition		47. Signature of other disposition		48. Signature of other disposition	
49. Signature of other disposition		50. Signature of other disposition		51. Signature of other disposition		52. Signature of other disposition	
53. Signature of other disposition		54. Signature of other disposition		55. Signature of other disposition		56. Signature of other disposition	
57. Signature of other disposition		58. Signature of other disposition		59. Signature of other disposition		60. Signature of other disposition	
61. Signature of other disposition		62. Signature of other disposition		63. Signature of other disposition		64. Signature of other disposition	
65. Signature of other disposition		66. Signature of other disposition		67. Signature of other disposition		68. Signature of other disposition	
69. Signature of other disposition		70. Signature of other disposition		71. Signature of other disposition		72. Signature of other disposition	
73. Signature of other disposition		74. Signature of other disposition		75. Signature of other disposition		76. Signature of other disposition	
77. Signature of other disposition		78. Signature of other disposition		79. Signature of other disposition		80. Signature of other disposition	
81. Signature of other disposition		82. Signature of other disposition		83. Signature of other disposition		84. Signature of other disposition	
85. Signature of other disposition		86. Signature of other disposition		87. Signature of other disposition		88. Signature of other disposition	
89. Signature of other disposition		90. Signature of other disposition		91. Signature of other disposition		92. Signature of other disposition	
93. Signature of other disposition		94. Signature of other disposition		95. Signature of other disposition		96. Signature of other disposition	
97. Signature of other disposition		98. Signature of other disposition		99. Signature of other disposition		100. Signature of other disposition	

12745

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12741

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8328 Draper Lane</u>			d. STREET ADDRESS <u>18328 Draper Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Charles Leon Beckunpough Jr.</u>			4. DATE OF DEATH Month <u>nov</u> Day <u>30</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23 1911</u>		9. AGE (In years last birthday) <u>47</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mastermind Engin.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ala</u>		11. BIRTHPLACE (State or foreign country) <u>Ala</u>	
13. FATHER'S NAME <u>Chas L Beckunpough Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Edna Parsons</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-3-0</u>		17. INFORMANT <u>Daisy Beckunpough (wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophageal tract</u> <u>153.9</u> DUE TO <u>with metastasis</u> Conditions, if any, which gave rise to immediate cause (b) (c) <u>stating the underlying cause lost.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>several mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>11-30-58</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>12/2/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Pk.</u>		22d. LOCATION (City, town, or county) <u>Falls Church, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

165b
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12746
CERTIFICATE OF DEATH

12742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>82 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Highland Park</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51X-3</u> d. STREET ADDRESS <u>801 Laurel Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Betty Lou Peterson</u>			4. DATE OF DEATH Month Day Year <u>November 27, 19 58</u>												
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 23, 1932</u>		9. AGE (In years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>5 24</u>		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receptionist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unascertainable</u>				11. BIRTHPLACE (State or foreign country) <u>Illinois</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Russell Batt</u>						14. MOTHER'S MAIDEN NAME <u>Mildred Roll</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>331-26-1824</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased Intra-Cranial Pressure</u> <u>173x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Choriocarcinoma, Metastatic</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> <u>9 mos.</u>															
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Bethesda</u>		(County) <u>Montgomery</u>		(State) <u>Md.</u>			
21. I certify that I attended the deceased from <u>September 6, 19 58</u> , to <u>November 27, 19 58</u> , that I last saw the deceased alive on <u>November 27, 19 58</u> , and that death occurred at <u>3:55 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11-27-58</u>															
ACTUAL SIGNATURE <u>Theodore L. Goodfriend</u> M.D.				The National Institutes of Health <u>Bethesda 14, Maryland</u>											
PHYSICIAN'S NAME (Type) <u>Theodore L. Goodfriend, M. D.</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 11/28/58</u>				22b. DATE THEREOF <u>11/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Gardens</u>		22d. LOCATION (City, town, or county) <u>N. Chicago, Illinois</u>		(State) <u>Illinois</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>						24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>							

CERTIFICATE OF DEATH

187

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

187

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	

12617

CERTIFICATE OF DEATH

12743

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Roma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington Sanitarium & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Scott PIGG Sr.</u>				4. DATE OF DEATH Month Day Year <u>11 - 18 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-18-11</u>	
9. AGE (In years lost birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary - Mail Carrier</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>Yancey W. Pigg</u>		14. MOTHER'S MAIDEN NAME <u>Florine Motherly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army - WWII</u>		16. SOCIAL SECURITY NO. <u>9 -</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Pulmonary edema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>hours</u> <u>hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> to <u>Nov 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 18</u> , 19 <u>58</u> , and that death occurred at <u>5:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.W. DAVIS</u>				ADDRESS (Street, city or town, state) <u>927 Crookway N.E.</u> DATE SIGNED <u>11-18-58</u>			
PHYSICIAN'S NAME (Type) <u>A.W. DAVIS</u>				M.D. <u>John Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Nov 20 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

Reg. No. 100-100

1. NAME OF DECEASED HASTARD		2. SEX Male		3. AGE 21		4. DATE OF BIRTH 1910		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Student		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Catholic		10. EDUCATION High School	
11. CAUSE OF DEATH Pneumonia		12. PLACE OF DEATH Home		13. DATE OF DEATH 1931		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF DECEASED (If living)	
16. SIGNATURE OF PHYSICIAN J. H. Smith		17. SIGNATURE OF MINISTER OF THE GOSPEL W. J. Brown		18. SIGNATURE OF CORONER C. D. Jones		19. SIGNATURE OF WITNESSES A. B. White, C. D. Green		20. SIGNATURE OF REGISTRAR D. E. Black	
21. NAME OF FUNERAL HOME F. G. H. Funeral Home		22. NAME OF CEMETERY St. Mary's Cemetery		23. NAME OF BURIAL PLACE Lot 10, Grave 15		24. NAME OF INTERMENT Interment		25. NAME OF CREMATION No	
26. NAME OF NEXT OF KIN J. K. L.		27. NAME OF SURVIVORS None		28. NAME OF DECEASED'S MOTHER M. N. O.		29. NAME OF DECEASED'S FATHER P. Q. R.		30. NAME OF DECEASED'S SISTER S. T. U.	
31. NAME OF DECEASED'S BROTHER V. W. X.		32. NAME OF DECEASED'S UNCLE Y. Z. A.		33. NAME OF DECEASED'S AUNT B. C. D.		34. NAME OF DECEASED'S Nephew E. F. G.		35. NAME OF DECEASED'S Niece H. I. J.	
36. NAME OF DECEASED'S Grandfather K. L. M.		37. NAME OF DECEASED'S Grandmother N. O. P.		38. NAME OF DECEASED'S Grandfather Q. R. S.		39. NAME OF DECEASED'S Grandmother T. U. V.		40. NAME OF DECEASED'S Grandfather W. X. Y.	
41. NAME OF DECEASED'S Grandmother Z. A. B.		42. NAME OF DECEASED'S Grandfather C. D. E.		43. NAME OF DECEASED'S Grandmother F. G. H.		44. NAME OF DECEASED'S Grandfather I. J. K.		45. NAME OF DECEASED'S Grandmother L. M. N.	
46. NAME OF DECEASED'S Grandfather O. P. Q.		47. NAME OF DECEASED'S Grandmother R. S. T.		48. NAME OF DECEASED'S Grandfather U. V. W.		49. NAME OF DECEASED'S Grandmother X. Y. Z.		50. NAME OF DECEASED'S Grandfather A. B. C.	
51. NAME OF DECEASED'S Grandmother D. E. F.		52. NAME OF DECEASED'S Grandfather G. H. I.		53. NAME OF DECEASED'S Grandmother J. K. L.		54. NAME OF DECEASED'S Grandfather M. N. O.		55. NAME OF DECEASED'S Grandmother P. Q. R.	
56. NAME OF DECEASED'S Grandfather S. T. U.		57. NAME OF DECEASED'S Grandmother V. W. X.		58. NAME OF DECEASED'S Grandfather Y. Z. A.		59. NAME OF DECEASED'S Grandmother B. C. D.		60. NAME OF DECEASED'S Grandfather E. F. G.	
61. NAME OF DECEASED'S Grandmother H. I. J.		62. NAME OF DECEASED'S Grandfather K. L. M.		63. NAME OF DECEASED'S Grandmother N. O. P.		64. NAME OF DECEASED'S Grandfather Q. R. S.		65. NAME OF DECEASED'S Grandmother T. U. V.	
66. NAME OF DECEASED'S Grandfather W. X. Y.		67. NAME OF DECEASED'S Grandmother Z. A. B.		68. NAME OF DECEASED'S Grandfather C. D. E.		69. NAME OF DECEASED'S Grandmother F. G. H.		70. NAME OF DECEASED'S Grandfather I. J. K.	
71. NAME OF DECEASED'S Grandmother L. M. N.		72. NAME OF DECEASED'S Grandfather O. P. Q.		73. NAME OF DECEASED'S Grandmother R. S. T.		74. NAME OF DECEASED'S Grandfather U. V. W.		75. NAME OF DECEASED'S Grandmother X. Y. Z.	
76. NAME OF DECEASED'S Grandfather A. B. C.		77. NAME OF DECEASED'S Grandmother D. E. F.		78. NAME OF DECEASED'S Grandfather G. H. I.		79. NAME OF DECEASED'S Grandmother J. K. L.		80. NAME OF DECEASED'S Grandfather M. N. O.	
81. NAME OF DECEASED'S Grandmother P. Q. R.		82. NAME OF DECEASED'S Grandfather S. T. U.		83. NAME OF DECEASED'S Grandmother V. W. X.		84. NAME OF DECEASED'S Grandfather Y. Z. A.		85. NAME OF DECEASED'S Grandmother B. C. D.	
86. NAME OF DECEASED'S Grandfather E. F. G.		87. NAME OF DECEASED'S Grandmother H. I. J.		88. NAME OF DECEASED'S Grandfather K. L. M.		89. NAME OF DECEASED'S Grandmother N. O. P.		90. NAME OF DECEASED'S Grandfather Q. R. S.	
91. NAME OF DECEASED'S Grandmother T. U. V.		92. NAME OF DECEASED'S Grandfather W. X. Y.		93. NAME OF DECEASED'S Grandmother Z. A. B.		94. NAME OF DECEASED'S Grandfather C. D. E.		95. NAME OF DECEASED'S Grandmother F. G. H.	
96. NAME OF DECEASED'S Grandfather I. J. K.		97. NAME OF DECEASED'S Grandmother L. M. N.		98. NAME OF DECEASED'S Grandfather O. P. Q.		99. NAME OF DECEASED'S Grandmother R. S. T.		100. NAME OF DECEASED'S Grandfather U. V. W.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12747

CERTIFICATE OF DEATH

12744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>78 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>10041 Counselman Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Joseph</u> Last <u>Plenni</u>				4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 9, 1920</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreign Service Officer</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Joseph W. Plenni</u>			
14. MOTHER'S MAIDEN NAME <u>Hannah Ilse</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW II		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>204.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CHRONIC MYELOCYTIC LEUKEMIA</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> <u>3 YRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u> <u>ANEMIA</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u> </u> Day <u>19</u> Year <u> </u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 19, 1958</u> to <u>November 5, 1958</u> , that I last saw the deceased alive on <u>November 5, 1958</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>I. Bernard Weinstein</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/5/58</u>			
PHYSICIAN'S NAME (Type) <u>I. Bernard Weinstein, M. D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased
2. Sex
3. Race
4. Date of birth
5. Place of birth
6. Date of death
7. Place of death
8. Cause of death
9. Manner of death
10. Signature of physician
11. Signature of registrar
12. Signature of informant

Robert A. Humphrey-Bellows, M.D.
Bureau of Health Statistics
National Center for Health Statistics
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12748

CERTIFICATE OF DEATH

12745

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. M. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park d. STREET ADDRESS c/o St. Mary's Rol-A-Rink e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Leonard POOLE, JR.		4. DATE OF DEATH Month Day Year November 6 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-58
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - -	
11. BIRTHPLACE (State or foreign country) Patuxent River, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James L. POOLE		14. MOTHER'S MAIDEN NAME Betty M. BRENSINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline membrane disease 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 5, 1958 , to November 6, 1958 , that I last saw the deceased alive on November 5, 1958 , and that death occurred at 4:15A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. L. Walton		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC	
PHYSICIAN'S NAME (Type) H. L. WALTON, LT, MC, USN		DATE SIGNED 11-6-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		24a. REC'D BY REGISTRAR Arthur S. Kline	
ADDRESS R. A. Pumphrey Funeral Home, 7557 Wisc. Ave., Bethesda, Md. '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

Name of Deceased [Name]		Date of Birth [Date]		Sex [Sex]	
Date of Death [Date]		Time of Death [Time]		Place of Death [Place]	
Cause of Death [Cause]		Manner of Death [Manner]		Signature of Physician [Signature]	
Signature of Registrar [Signature]		Date of Registration [Date]		Office of Registrar [Office]	

CERTIFICATE OF DEATH

12746

Reg. Dist. No.

12749

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DICKERSON RTE 1				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DICKERSON RTE 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARSHALL NEWLAND POTEAT				4. DATE OF DEATH Month Day Year 11 13 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-15	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 4 10		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MARKETING SPECIALIST		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES S. POTEAT				14. MOTHER'S MAIDEN NAME MAUDE ESTELLE SIMMONS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WWII		16. SOCIAL SECURITY NO. None		17. INFORMANT MARY V. POTEAT		Address DICKERSON, RTE 1, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intercerebral Hemorrhage DUE TO (c) Dissecting Aneurysm of Middle Cerebral Artery				INTERVAL BETWEEN ONSET AND DEATH Hours Days Weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 1953 , to 11-13, 1958 , that I last saw the deceased alive on 9-10, 1958 , and that death occurred at 10:25 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE W. G. Hall				M.D. 615 W. Montgomery Ave. Rockville, Md. 11/13/58			
PHYSICIAN'S NAME (Type) W. G. Hall				615 W. Montgomery Ave. Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR NOV 17 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hays			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

12750

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

12751

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 112 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x-3 d. STREET ADDRESS 4519 Nebraska Ave., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle J. Last QUICK		4. DATE OF DEATH Month November Day 26 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-02
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diplomatic Service		10b. KIND OF BUSINESS OR INDUSTRY U.S. Dept. of State	
11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Walter J. QUICK		14. MOTHER'S MAIDEN NAME Mary MITCHELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT (W) Mrs. Cleo P. Quick, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia, myelogenous, acute 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 6 MOS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 6, 1958 , to November 26, 1958 , that I last saw the deceased alive on November 26, 1958 , and that death occurred at 1:15P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED US Naval Hospital, NNMC 11-26-58			
ACTUAL SIGNATURE J. T. Horgan		M.D. US Naval Hospital, NNMC	
PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR MC, USN		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-29-58	22c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Rockville Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's Sons		24a. REC'D BY REGISTRAR DEC 2 '58	
ADDRESS 1756 Renna. Ave. NW, Wash. DC		24b. REGISTRAR'S SIGNATURE Arthur S. Finner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12752 CERTIFICATE OF DEATH

12749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Washington, D.C. 47x3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5621 McLean Drive				d. STREET ADDRESS 6141 31st. St., NW 1621X McLean Dr. NW			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ELLEN Middle Cecelia Last Quinn		4. DATE OF DEATH Month Nov. Day 30 Year 1958					
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-28-68	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months 7 Days 30 Hours 19 Min. 58		IF UNDER 24 HRS. Hours 19 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeremiah Quinn				14. MOTHER'S MAIDEN NAME Bridget Ryan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Helen Daly Address 5621 McLean Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) stroke						INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 20, 1958 , to Nov 30, 1958 , that I last saw the deceased alive on Nov 28, 1958 , and that death occurred at 1:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. Nolan M.D.				DATE SIGNED 5401 Western Ave NW			
PHYSICIAN'S NAME (Type) JAMES E. NOLAN				Address Washington DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-2-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.				24a. REC'D BY REGISTRAR DEC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12750

12753

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 10 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle Charles Last RAMM		4. DATE OF DEATH Month November Day 27 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-1896
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John (n) RAMM		14. MOTHER'S MAIDEN NAME Johoana KRUGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI WW2		16. SOCIAL SECURITY NO. 564-10-7328	
17. INFORMANT Alice H. RAMM		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse Metastases 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Carcinoma (Epidermoid) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 mo - 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 November 1958 to 27 November 1958 , that I last saw the deceased alive on 27 November 1958 , and that death occurred at 9:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11-28-58 DATE SIGNED			
ACTUAL SIGNATURE John W. Davis		M.D. U.S. Naval Hospital, Bethesda, Md	
PHYSICIAN'S NAME (Type) J. W. DAVIS, LT MC, USN		U.S. Naval Hospital, Bethesda, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-1-58	22c. NAME OF CEMETERY OR CREMATORY Arlington	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE R. J. MURPHY Home 3524 Columbia Pike ADDRESS Arlington, Va.		24a. REC'D BY REGISTRAR DATE DEC 2 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
1928
CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John (a) [illegible]		[illegible]	
Age		Sex	
[illegible]		[illegible]	
Place of Birth		Date of Birth	
[illegible]		[illegible]	
Usual Residence		Cause of Death	
[illegible]		[illegible]	
Occupation		Signature of Physician	
[illegible]		[illegible]	
Signature of Registrar		Signature of Coroner	
[illegible]		[illegible]	
Date of Registration		Place of Registration	
[illegible]		[illegible]	

12754

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8608 Broadmoore Dr.			d. STREET ADDRESS 8608 Broadmoore Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Edna M Ramsey			4. DATE OF DEATH Month Nov. Day 24 Year 1958		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 30, 1887		9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) N.Y.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles E. Main			14. MOTHER'S MAIDEN NAME Frances Lasabair		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. F. Ramsey Address Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Nov. 24, 1958	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Hill	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR NOV 28 '58	
				24b. REGISTRAR'S SIGNATURE <i>John A. ...</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES EARL RAY		35		Male		White		Methodist	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
Nov. 24, 1968		Baltimore, Md.		Suicide		Homicide		Suicide	
TIME OF DEATH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARITAL STATUS	
11:00 AM		Baltimore, Md.		High School		None		Single	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARITAL STATUS	
Nov. 24, 1933		Baltimore, Md.		High School		None		Single	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
Nov. 24, 1968		Baltimore, Md.		Suicide		Homicide		Suicide	
TIME OF DEATH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARITAL STATUS	
11:00 AM		Baltimore, Md.		High School		None		Single	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARITAL STATUS	
Nov. 24, 1933		Baltimore, Md.		High School		None		Single	



INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12752

12755 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>MARYLAND</u>		STATE <u>D. C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u> <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Althea Woodland Nur. Home</u>				STREET ADDRESS (If rural give location) <u>1819 G. St. N.W.</u>			
3. NAME OF DECEASED (Type or Print) <u>William S. Rice</u> (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 1, 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATE <u>Single</u>	8. DATE OF BIRTH <u>Oct. 1 1899</u>		9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Willard Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Memphis, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Jesse M. Rice</u>				14. MOTHER'S MAIDEN NAME <u>Ida Broadway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes. World War I & 2</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Nursing Home</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
162.1 IMMEDIATE CAUSE (A) <u>Asphyxiation due to</u> ANTECEDENT CAUSE(S) DUE TO <u>Copernoma - bronchogenic</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				<u>15 min</u> <u>4 mo</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1958</u> to <u>Nov. 1, 1958</u> that I last saw the deceased alive on <u>10-28-58</u> and that death occurred at <u>6:45</u> M, from the causes and on the date stated above. <u>11-1-58</u> SIGNATURE <u>Samuel M. Mowbray</u> ADDRESS (Street, city, town, state) <u>3200-16 St. NW. Wash. D.C.</u> DATE SIGNED 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>11/5/58</u> NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> LOCATION (City, town, or county) <u>Arlington Co., Virginia</u> (State)							
24. REC'D BY REGISTRAR <u>NOV 5 '58</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Heatley Funeral Home, Alexandria, Va.</u>		ADDRESS	

CERTIFICATE OF DEATH

Page One

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Manner of death

9. Name of physician

10. Name of attending physician

11. Name of coroner

12. Name of registrar

13. Name of informant

14. Name of informant

15. Name of informant

16. Name of informant

17. Name of informant

18. Name of informant

19. Name of informant

20. Name of informant

21. Name of informant

22. Name of informant

23. Name of informant

24. Name of informant

25. Name of informant

26. Name of informant

27. Name of informant

28. Name of informant

29. Name of informant

30. Name of informant

31. Name of informant

32. Name of informant

33. Name of informant

34. Name of informant

35. Name of informant

36. Name of informant

37. Name of informant

38. Name of informant

39. Name of informant

40. Name of informant

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 236 12-11-58 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12753

12756

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 20 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater d. STREET ADDRESS Route #2, Box 215 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emily Elizabeth RINARD		4. DATE OF DEATH Month Day Year November 30 19 58	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-08
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - -	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Soloman SHUEY		14. MOTHER'S MAIDEN NAME Bertha Levina TYLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (H) Ellis B. Rinard, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary site: Right breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 10, 19 58 , to November 30, 19 58 , that I last saw the deceased alive on November 30, 19 58 , and that death occurred at 7:20A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NNMC 12-1-58			
ACTUAL SIGNATURE Douglas R. Koth		M.D. U. S. Naval Hospital, NNMC	
PHYSICIAN'S NAME (Type) D. R. KOTH, LT, MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-2-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. J. HODGINS, Jr., Annapolis, Md.		24a. REC'D BY REGISTRAR DEC 3 58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

12757

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 84 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stephens City 83X-3			
3. NAME OF DECEASED (Type or print) First Charles Middle Oliver Last Ritenour, Jr.				4. DATE OF DEATH Month November Day 2 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 9, 1946	
9. AGE (In years last birthday) 12 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles O. Ritenour, Sr.				14. MOTHER'S MAIDEN NAME Mary Cave			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service No				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record				18. ADDRESS The Clinical Center, Bethesda 14, Maryland			
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Diathesis, of 2043 DUE TO Brain, Esophagus, Intestine & Kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute leukemia (c) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 yr							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 10, 1958 , to November 2, 1958 , that I last saw the deceased alive on November 2, 1958 , and that death occurred at 2:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 11/3/58 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Nathan S. Taylor M.D.				PHYSICIAN'S NAME (Type) Nathan S. Taylor, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/58		22c. NAME OF CEMETERY OR CREMATORY Macadonia		22d. LOCATION (City, town, or county) (State) Frederick County, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Knecht	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF BIRTH

12757

Name of Child		John William	
Sex		Male	
Date of Birth		November 10, 1958	
Place of Birth		The University Hospital, Baltimore, Md.	
Parents		Charles A. Johnson, Sr. and Mary Jane Johnson	
Address		1234 Elm Street, Baltimore, Md.	
Occupation of Father		Teacher	
Occupation of Mother		Homemaker	
Signature of Registrar		[Signature]	
Signature of Physician		[Signature]	
Signature of Midwife		[Signature]	
Signature of Nurse		[Signature]	
Signature of Hospital Representative		[Signature]	
Signature of Local Health Officer		[Signature]	
Signature of State Health Officer		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12758

CERTIFICATE OF DEATH

12755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 1615.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanitarium</u>		d. STREET ADDRESS <u>4901-42nd Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>OLEGIA</u> Middle <u>BELL</u> Last <u>ROBINSON</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/1890</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife own home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Assistant</u>	
11. BIRTHPLACE (State or foreign country) <u>Ala</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Brittian</u>		14. MOTHER'S MAIDEN NAME <u>Posey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Harry T. Robinson</u> Address <u>son</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE HEART DISEASE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 23, 1954</u> to <u>NOV. 17, 1958</u> , that I last saw the deceased alive on <u>NOV. 17, 1958</u> , and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5206 Norway Dr.</u> DATE SIGNED <u>11/17/58</u> ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D. PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u> <u>Cherry Chase, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 20 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED JAMES H. HARRIS</p>		<p>2. SEX Male</p>	
<p>3. AGE 65</p>		<p>4. DATE OF BIRTH 1888</p>	
<p>5. PLACE OF BIRTH Baltimore, Md.</p>		<p>6. OCCUPATION Clerk</p>	
<p>7. MARITAL STATUS Married</p>		<p>8. DATE OF MARRIAGE 1915</p>	
<p>9. NAME OF SPOUSE Mary E. Harris</p>		<p>10. DATE OF DEATH 1953</p>	
<p>11. PLACE OF DEATH Baltimore, Md.</p>		<p>12. CAUSE OF DEATH Heart Disease</p>	
<p>13. MEDICAL HISTORY Hypertension, Atherosclerosis</p>		<p>14. PRESENT ILLNESS Angina Pectoris</p>	
<p>15. TREATMENT Medical</p>		<p>16. PLACE OF INTERMENT St. Mary's Cemetery</p>	
<p>17. SIGNATURE OF PHYSICIAN J. H. Smith</p>		<p>18. SIGNATURE OF REGISTRAR A. B. Jones</p>	

Report on the Acidic
Hypostatic Process
Myocardial Infarct

11-22
9:24

15-51

95-21

[Faint handwritten notes]

Handwritten: Mrs Mary Thompson

12760

CERTIFICATE OF DEATH

12757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 6 months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1608 East-West Highway	
d. STREET ADDRESS 1608 East-West Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle CLARA Last SANDERSON		4. DATE OF DEATH Month NOV. Day 2 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 6, 1866
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) FT. FOOTE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS H. GRAY		14. MOTHER'S MAIDEN NAME ELLEN SCHAEFFER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Geo. T. Robey, 1608 East-West Highway		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC LYMPHATIC LEUKEMIA 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE , 19 58 , to 2 NOV. , 19 58 , that I last saw the deceased alive on 2 NOV. , 19 58 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE L.B. Snow		M.D. 9013 FLOWER AVE. 11/2/58	
PHYSICIAN'S NAME (Type) L. B. SNOW		ADDRESS (Street, city or town, state) SILVER SPRING, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		22b. DATE THEREOF 11/5/58	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN MAUSOLEUM		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Burke		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR NOV 5 '58		24b. REGISTRAR'S SIGNATURE G. H. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12761 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12758

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8215 Old Georgetown Rd Bethesda</u>		c. LENGTH OF STAY IN lb <u>few min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beth-ell Synog.</u>			d. STREET ADDRESS <u>4700 Bradley Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nathan</u> Middle <u>L</u> Last <u>Sanow</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 Oct 1891</u>		9. AGE (in years) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engr</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rochester N. Y.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Louis Sanow</u>			14. MOTHER'S MAIDEN NAME <u>Ann (Unknown)</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Son</u> <u>Kenneth Sanow</u> Address <u>6525 Elgin Lane Beth Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/4/58</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Britton Road</u>	
22d. LOCATION (City, town, or county) (State) <u>Rochester, New York</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217 - 9th. St. N.W. Washington, D.C.</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12762

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56-594 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Beatrice Middle M. Last Scarlis				4. DATE OF DEATH Month Nov. Day 9 Year 1958			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1903	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months X Days X	IF UNDER 24 HRS. Hours X Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Riley				14. MOTHER'S MAIDEN NAME Louise Dunnigan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Shirley Scarlis			Address (Silver Spring, Md.) 594 University Blvd. E.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast with metastases DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH @ 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 19 Day 19 Year 1958 Hour a. m. p. m.			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 5, 1956 to Nov 9, 1958 , that I last saw the deceased alive on Nov 9, 1958 , and that death occurred at 11 P M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard L Fitzgerald				ADDRESS (Street, city or town, state) 217 University Blvd E Silver Spring Md		DATE SIGNED 11/10/58	
PHYSICIAN'S NAME (Type) Bernard Fitzgerald							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-58		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey Inc.				ADDRESS 8434 Georgia Ave. Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE NOV 12 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12763

CERTIFICATE OF DEATH

12760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Linda</u> Middle <u>Darlene</u> Last <u>Schmidt</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 19, 1947</u>	
9. AGE (In years last birthday) <u>11</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Hours <u>2</u> Min.		IF UNDER 24 HRS. Months <u>11</u> Days <u>15</u> Hours <u>2</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Harvey D. Schmidt</u>				14. MOTHER'S MAIDEN NAME <u>Lena Montgomery</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or date of service] <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TETRALOGY OF Fallot-postoperative</u> <u>754.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>October 26, 1958</u> , to <u>November 15, 1958</u> , that I last saw the deceased alive on <u>November 15, 1958</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon I. Goldberg</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11-15-58</u>			
PHYSICIAN'S NAME (Type) <u>Leon I. Goldberg, M. D.</u>				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 18, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12764

CERTIFICATE OF DEATH

12761

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
3. NAME OF DECEASED (Type or print) First Christine Middle Mary Last Seabolt		4. DATE OF DEATH Month November Day 24 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1936
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months 2 Days 24 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ernest Atwell		14. MOTHER'S MAIDEN NAME Zenola Tibbs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-6744	
17. INFORMANT Hospital records		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia DUE TO (c) Hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 days 6 months 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/28 , 19 58 , to 11/24 , 19 58 , that I last saw the deceased alive on 11/24 , 19 58 , and that death occurred at 6:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) Sandy Spring, Maryland	
DATE SIGNED 11/25/58			
PHYSICIAN'S NAME (Type) C. H. Ligon, M. D.		Sandy Spring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE-TIME OF 11/28/58	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR NOV 28 58		24b. REGISTRAR'S SIGNATURE [Signature]	

LAW AND STATE DEPARTMENT OF HEALTH - BALTIMORE 11

1. 2. 3.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 3 and 4 should be filled with the necessary information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12765

CERTIFICATE OF DEATH

12762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 28 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9205 2nd Avenue				d. STREET ADDRESS 9205 2nd Avenue			
3. NAME OF DECEASED (Type or print) First REBECCA Middle C. Last SHAW				4. DATE OF DEATH Month NOVEMBER Day 15 Year 58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/20/74		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown Shearin				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-10-0420-A		17. INFORMANT Mrs. Calvin W. Schaeffer, 9205 2nd Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE Immed. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDITIS AND MILD CHRONIC DUE TO (c) GENERALIZED ARTERIOSCLEROSIS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. NONE 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State) X	
21. I certify that I attended the deceased from 1954 to 15 NOV. , 19 58 , that I last saw the deceased alive on 6 NOV. , 19 58 , and that death occurred at 8:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Marshall Cuvillier, Jr. PHYSICIAN'S NAME (Type) L. MARSHALL CUVILLIER, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/18/58		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc. Raymond E. Pumphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE NOV 19 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

MASSACHUSETTS DEPARTMENT OF HEALTH-BATTLING ONE OF THE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12766
CERTIFICATE OF DEATH

12763

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>California</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>46 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Los Angeles 56</u> 43 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>5918 Wooster Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Rhoda</u>		First Middle Last <u>(none)</u> <u>Sherbecoe</u>		4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 26, 1923</u>		9. AGE (In years last birthday) <u>35</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel J. Ross</u>				14. MOTHER'S MAIDEN NAME <u>Sophia London</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>046-18-5448</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Nervous System Depression</u> 1950 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Adreno-Cortical Carcinoma</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>October 8</u> , 19 <u>58</u> , to <u>November 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>November 23</u> , 19 <u>58</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>11/23/58</u>							
ACTUAL SIGNATURE <u>Theodore L. Goodfriend</u> M.D.		The Clinical Center					
PHYSICIAN'S NAME (Type) <u>Theodore L. Goodfriend, M. D.</u>		The National Institutes of Health					
		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 27, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillside Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Los Angeles, California</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin P. Adams</u>				ADDRESS <u>3501-14 St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 26 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF CALIFORNIA - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1910

<p>NAME OF DECEASED</p>		<p>DATE OF DEATH</p>	
<p>AGE</p>		<p>SEX</p>	
<p>PLACE OF BIRTH</p>		<p>DATE OF BIRTH</p>	
<p>CAUSE OF DEATH</p>		<p>PLACE OF DEATH</p>	
<p>DATE OF INTERMENT</p>		<p>PLACE OF INTERMENT</p>	
<p>SIGNATURE OF REGISTRAR</p>		<p>DATE</p>	
<p>SIGNATURE OF PHYSICIAN</p>		<p>DATE</p>	
<p>SIGNATURE OF FUNERAL HOME</p>		<p>DATE</p>	
<p>SIGNATURE OF WITNESS</p>		<p>DATE</p>	
<p>SIGNATURE OF CLERK</p>		<p>DATE</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12767 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12764

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

M

74

I

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 43 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital			d. STREET ADDRESS 11005 Locust Drive		
3. NAME OF DECEASED (Type or print) Eloise			4. DATE OF DEATH November 25 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1902		9. AGE (in years last birthday) 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Homemaker-Telephone operator at		10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Naval Med. Center Frank Hilton			14. MOTHER'S MAIDEN NAME Hallie Bohrer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-10-8532		17. INFORMANT Gladys V. White	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral contusion & laceration 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of skull (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 days			INTERVAL BETWEEN ONSET AND DEATH 2 days		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down basement steps at home			
20c. TIME OF INJURY Month, Day, Year 11-23 1958		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) home	
20f. (City or town) Damascus		20g. (County) Montgomery		20h. (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschant		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-25-58	
EXAMINER'S NAME (Type) FRANK J. Broschant		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 27, 1958		22c. NAME OF CEMETERY OR CREMATORY Damascus Methodist	
22d. LOCATION (City, town, or county) Damascus, Md.		24a. REC'D BY REGISTRAR NOV 28 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Mohrwith, Damascus, Md					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12768

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12765

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brinklow		c. LENGTH OF STAY IN 1b X Brinklow	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brighten Dam Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sydney Snowden Stabler		4. DATE OF DEATH Month Nov. Day 11, Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired U.S. Agriculturist		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Augustas Stabler		14. MOTHER'S MAIDEN NAME Helen Snowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Sidney Stabler Jr.,		Address Brookville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Found dead in bed.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Nov. 10, 1958	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Cremation NOV. 11		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber		ADDRESS Laytonsville, Md	
24a. REC'D BY REGISTRAR NOV 12 '58		DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

FOR STATE
DEPARTMENT

RECEIVED FROM

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased [Illegible]		2. Sex [Illegible]	
3. Age [Illegible]		4. Date of Death [Illegible]	
5. Place of Birth [Illegible]		6. Usual Residence [Illegible]	
7. Occupation [Illegible]		8. Cause of Death [Illegible]	
9. Manner of Death [Illegible]		10. Signature of Medical Examiner [Illegible]	
11. Date of Report [Illegible]		12. Signature of Registrar [Illegible]	

12769

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY Charleston c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 77x-3 d. STREET ADDRESS The Citadel e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edward Henry Starr				4. DATE OF DEATH Month Day Year November 11 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 26, 1953	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert C. Starr				14. MOTHER'S MAIDEN NAME Barbara Brixon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) surgery for bleeding gastric ulcer (c) post-operative status - Closure of peritoneal cavity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (SECONDARY TO GIVEN IN PART I (a)) 90 days INTERVAL BETWEEN ONSET AND DEATH immed. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 October 1958 to November 11, 1958 , that I last saw the deceased alive on November 11, 1958 , and that death occurred at 3:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 11/11/58 National Institutes of Health							
ACTUAL SIGNATURE William W. Pfaff PHYSICIAN'S NAME (Type) William W. Pfaff, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11/12/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR NOV 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. King	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12618

Item 14 Film G236 11-20-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12767

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>10902 New Hampshire Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				d. STREET ADDRESS <u>White Oaks, Silver Spring</u>			
3. NAME OF DECEASED (Type or print) First <u>Irvin</u> Middle <u>Jesse</u> Last <u>Stewart</u>				4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 5, 1895</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>		11. BIRTHPLACE (State or foreign country) <u>EMERSON VALLEY, PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB STEWART</u>				14. MOTHER'S MAIDEN NAME <u>"Not available"</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs GERTRUDE E. STEWART</u> Address <u>10902 N.H. AVE., SS MD.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Infarction massive</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 days</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Nov 7, 1958</u> , to <u>Nov 13, 1958</u> , that I last saw the deceased alive on <u>Nov 13, 1958</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest A. Sarao</u>				ADDRESS (Street, city or town, state) <u>7006 New Hampshire Ave Takoma Park</u> DATE SIGNED <u>11/14/58</u>			
PHYSICIAN'S NAME (Type) <u>ERNEST A SARAO</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov 17, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL CEM</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Harris</u> ADDRESS <u>254 CARROLL ST. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 10/57

1
M
73
1
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12770

CERTIFICATE OF DEATH

Reg. Dist. No.

12768

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>7 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Strickland</u> Last <u>Strickland</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 71</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or up-down) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>491X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the left breast</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 7, 19 58</u> , to <u>November 9 19 58</u> , that I last saw the deceased alive on <u>November 9, 19 58</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clarksville, Md.</u> DATE SIGNED <u>11-10-58</u>			
ACTUAL SIGNATURE <u>C. S. Whitaker, M.D.</u> M.D.		PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Nov. 10</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Newport</u>		22d. LOCATION (City, town, or county) (State) <u>Newport New Hampshire</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 1 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1878		CINCINNATI		OHIO		OHIO		OHIO	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
Carpenter		Heart Disease		Natural		10 days		1923		CINCINNATI		OHIO		OHIO		OHIO	
FATHER'S NAME		MOTHER'S NAME		MARRIAGE		EDUCATION		RELIGION		SCHOOL		CITY		COUNTY		STATE	
JAMES H. HARRIS		MARY J. HARRIS		1898		8 years		Roman Catholic		CINCINNATI		OHIO		OHIO		OHIO	
DATE OF MARRIAGE		DATE OF DEATH		DATE OF BURIAL		DATE OF INTERMENT		DATE OF CREMATION		DATE OF EXHUMATION		DATE OF REINTERMENT		DATE OF REINTERMENT		DATE OF REINTERMENT	
1900		1923		1923		1923		1923		1923		1923		1923		1923	
DATE OF DEATH		DATE OF BURIAL		DATE OF INTERMENT		DATE OF CREMATION		DATE OF EXHUMATION		DATE OF REINTERMENT		DATE OF REINTERMENT		DATE OF REINTERMENT		DATE OF REINTERMENT	
1923		1923		1923		1923		1923		1923		1923		1923		1923	
DATE OF DEATH		DATE OF BURIAL		DATE OF INTERMENT		DATE OF CREMATION		DATE OF EXHUMATION		DATE OF REINTERMENT		DATE OF REINTERMENT		DATE OF REINTERMENT		DATE OF REINTERMENT	
1923		1923		1923		1923		1923		1923		1923		1923		1923	

CINCINNATI, OHIO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12771

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12769

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 4½ hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Washington Forest (Washington 22, D. C.) d. STREET ADDRESS 8519 Van Buren Drive 16X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Karen First Bradford Middle STRUVEN Last		4. DATE OF DEATH Month November Day 24 Year 19 58	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - -	
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert L. STRUVEN		14. MOTHER'S MAIDEN NAME Marion B. POWERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Robt. L. Struven, same as #2 above.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hyaline Membrane Disease 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 24, 1958 , to November 24, 1958 , that I last saw the deceased alive on November 24, 1958 , and that death occurred at 9:17 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED 11-25-58			
ACTUAL SIGNATURE David Harris		M.D. U. S. Naval Hospital, NNMC	
PHYSICIAN'S NAME (Type) David HARRIS, LT MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 11-26-58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hills	22d. LOCATION (City, town, or county) (State) Suitland Md.
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, 7557 Wisc. Ave.		24a. REC'D BY REGISTRAR NOV 28 '58	24b. REGISTRAR'S SIGNATURE Charles L. Howard

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RECEIVED
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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Name (Last, First, Middle) JAMES EARL RAY		Sex Male		Date of Birth 5-3-26	
Place of Birth Jackson, Tennessee		Race White		Height 5-11	
Weight 175		Complexion Fair		Build Slender	
Education High School Graduate		Occupation Minister of the Gospel		Religion Methodist	
Marital Status Single		Social Security Number 4-38-75		Maiden Name None	
Date of Death 6-6-68		Place of Death Memphis, Tennessee		Cause of Death Suicide	
Immediate Cause of Death Self-inflicted gunshot wound		Underlying Cause of Death Depression		Manner of Death Suicide	
Physician's Signature [Signature]		Physician's Name Dr. [Name]		Physician's Address [Address]	
Medical Examiner's Signature [Signature]		Medical Examiner's Name Dr. [Name]		Medical Examiner's Address [Address]	
Coroner's Signature [Signature]		Coroner's Name [Name]		Coroner's Address [Address]	
Registrar's Signature [Signature]		Registrar's Name [Name]		Registrar's Address [Address]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12772

CERTIFICATE OF DEATH

12770

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 133 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4013 No. Chesterbrook Road			
3. NAME OF DECEASED (Type or print) First David Middle Sargeant Last Swanson				4. DATE OF DEATH Month November Day 10 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 28, 1943	
9. AGE (In years lost birthday) 15 yrs.		IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) Florida	
10b. KIND OF BUSINESS OR INDUSTRY None		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Chandler W. Swanson		14. MOTHER'S MAIDEN NAME Ruth Sargeant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMOPERICARDIUM secondary to 178x DUE TO Embryonal rhabdomyosarcoma of left testis with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. widespread metastases. DUE TO 10 months. (b) widespread metastases. (c)							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from April 28, 19 58 , to November 10, 19 58 , that I last saw the deceased alive on November 10, 19 58 , and that death occurred at 9:07 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter S. Mueller, M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-10-58			
PHYSICIAN'S NAME (Type) Mueller, Peter S., M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR NOV 13 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12773

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12771

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY in 1b 16 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 47X-3 d. STREET ADDRESS 5120 Klinge Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Byron Edward Richard TAYLOR				4. DATE OF DEATH Month Day Year November 12 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-3-14	
9. AGE (In years last birthday) yrs. 44		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cartographer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Byron Edward TAYLOR			
14. MOTHER'S MAIDEN NAME Helen Gertrude ASH				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 3/36 - 2/46			
16. SOCIAL SECURITY NO. 578-38-4824				17. INFORMANT (W) Mrs. Marjorie G. Taylor, same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Appr. 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from October 27, 1958 , to November 12, 1958 , that I last saw the deceased alive on November 11, 1958 , and that death occurred at 1:12A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 11-12-58							
ACTUAL SIGNATURE A. T. Thorp, Jr.				M.D. U. S. Naval Hospital, NNM			
PHYSICIAN'S NAME (Type) A. T. THORP, JR.				Bethesda 14, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 3072 "M" St., N.W., Washington, DC				24a. REC'D BY REGISTRAR DATE NOV 13 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1977

Name of Deceased		Date of Birth		Sex		Race	
JAMES EARL RAY		5-10-1928		Male		White	
Place of Birth		Date of Death		Time of Death		Cause of Death	
Memphis, Tennessee		6-6-68		10:00 AM		Suicide	
Occupation		Manner of Death		Certified by		Physician	
Attorney at Law		Suicide		J. Edgar Hoover		FBI	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Death		Hospital		City	
6-10-68		FBI		FBI		FBI	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

127774		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		127772	
		CERTIFICATE OF DEATH		Reg. Dist. No. 215	
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 7 hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, NNMC		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1650 Harvard Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl THARP		4. DATE OF DEATH Month Day Year November 17 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-58	9. AGE (In years lost birthday) yrs. 7	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joel E. THARP			
14. MOTHER'S MAIDEN NAME Carmen Dolores WAGGNER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - immaturity (<1000 G.) 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 7 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from November 17, 1958 , to November 17, 1958 , that I last saw the deceased alive on November 17, 1958 , and that death occurred at 11:45 P. M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Howard A. Pearson		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC		DATE SIGNED 11-17-58	
PHYSICIAN'S NAME (Type) H. A. PEARSON, LT, MC, USN		Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-21-58	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines		ADDRESS 2901 14th St., N.W., Washington, DC		24a. REC'D BY REGISTRAR NOV 21 '58	
24b. REGISTRAR'S SIGNATURE Carlton S. Hines					

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12156

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

12156

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

TIME OF BIRTH

PLACE OF BIRTH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **12773**

Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2509 Randolph Rd</u>				d. STREET ADDRESS <u>2509 Randolph Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth Hall Todd</u>				4. DATE OF DEATH <u>11-17-58</u> 19 <u>58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-4-1878</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Ark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>
13. FATHER'S NAME <u>Wells Todd</u>			14. MOTHER'S MAIDEN NAME <u>Caroline E. Chester</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>JoAnn Berry - Same ID# 2</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebral Vascular Accident</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11-17-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>11/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12619

CERTIFICATE OF DEATH

Reg. Dist. No. 12774

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> 16X-2	
c. LENGTH OF STAY IN 1b <u>DOA.</u>		d. STREET ADDRESS <u>Washington Sanitarium 2214 Phelps Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gina</u> First <u>MICHELLE</u> Middle <u>Tunman</u> Last	4. DATE OF DEATH <u>11</u> Month <u>18</u> Day <u>19</u> Year <u>58</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-58</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>22</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest O. Tunman</u>		14. MOTHER'S MAIDEN NAME <u>Margaret M. Schoemig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mother + Father</u>		Address <u>Adelphi, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lungo-tracheo-bronchitis</u> <u>501X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute infection</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>approx one hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9:00 PM 11/18/58</u> to <u>10:00 AM 11/18/58</u> , that I last saw the deceased alive on <u>11/18</u> , 19 <u>58</u> , and that death occurred at <u>10:05</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Murray Paul</u>		ADDRESS (Street, city or town, state) <u>8106 New Hampshire Ave Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>MURRAY PAUL, M.D.</u>		DATE SIGNED <u>11/18/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/21/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond R. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>NOV 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Broschart has been notified
+ permission received to sign
certificate

Murray Paul, M.D. ✱
J.W.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
BM 2/57

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12775
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN fb D.O.A.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring d. STREET ADDRESS Atwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harvey R. Turner		4. DATE OF DEATH Nov. 8 1958		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug. 14, 1899		9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Indian Spring Country Club		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Turner		14. MOTHER'S MAIDEN NAME May Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Florence Turner	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20b. TIME OF INJURY Month, Day, Year 10-20-58		20c. INJURY OCCURRED While Not while While	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) Silver Spring		20f. (County) Montgomery	
20g. (State) MD.		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/11/58		22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE CEMETERY	
22d. LOCATION (City, town, or county) BURTONSVILLE, MONTGOMERY CO., MD.		22e. NAME OF CEMETERY OR CREMATORY BURTONSVILLE CEMETERY		22f. LOCATION (City, town, or county) BURTONSVILLE, MONTGOMERY CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC., Silver Spring, Md. Raymond A. Giska		24a. REC'D BY REGISTRAR NOV 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

1917

1917
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HAWAIIAN STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

1917

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is divided into several columns and rows for detailed data entry.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 3, Film G-235 11/17/58, cag										
12777										
12777										
Reg. Dist. No.										
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>1 2704 Urbana Ave.</u>					
3. NAME OF DECEASED (Type or print) <u>JON</u> First <u>PAUL</u> Middle <u>PAUL</u> Last <u>VASBINDER</u>					4. DATE OF DEATH <u>NOVEMBER 13 1958</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 13 1958</u>		9. AGE (In years lost birthday) yrs. <u>1</u> IF UNDER 1 YEAR Months Days Hours Min. <u>45</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES WILLIAM VASBINDER</u>					14. MOTHER'S MAIDEN NAME <u>DAISY MARIE SIMON</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>FATHER</u> , Item #2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Heart Attack (6th month)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/13</u> , 19 <u>58</u> , to <u>11/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/13</u> , 19 <u>58</u> , and that death occurred at <u>10:10</u> M., from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>Sam Allen</u> M.D. <u>Kensington, Md.</u>					ADDRESS (Street, city or town, state) <u>11/14/58</u>					
PHYSICIAN'S NAME (Type) <u>SAM ALLEN, M.D.</u>					DATE SIGNED <u>11/14/58</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>			22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>					24a. REC'D BY REGISTRAR DATE <u>NOV 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

2074335XV0

THE UNIVERSITY OF CHICAGO PRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

12777

Item 18 Film 237 1-13-59 ams

12778

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE N. J. b. COUNTY BURLINGTON									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHERRY CHASE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOORESTOWN 672-3 ✓									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6810 BROOKVILLE RD.				d. STREET ADDRESS R.D. # 5			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH WAITON				4. DATE OF DEATH Month Day Year NOV 28 1958									
5. SEX FEMALE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 15, 1903 33 yrs.		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROFESSOR OF SOCIAL SERVICE TEACHER				10b. KIND OF BUSINESS OR INDUSTRY N. J.				11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME SILAS WAITON				14. MOTHER'S MAIDEN NAME MARY BROOKS JONES									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Joseph L. Walton - 6810 Brookville Rd. Cherry Chase Ind.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 153.8 DUE TO Ca of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 year													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from September 1958 , to Nov. 28, 1958 , that I last saw the deceased alive on Nov 26, 1958 , and that death occurred at 3:25 P. M. from the causes and on the date stated above.													
ACTUAL SIGNATURE Irene G. Tamagna				ADDRESS (Street, city or town, state) 7101 CONN. AVE. Ch. H. Md.				DATE SIGNED					
PHYSICIAN'S NAME (Type) IRENE G TAMAGNA													
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION				22b. DATE THEREOF 11-29-58		22c. NAME OF CEMETERY OR CREMATORY Lees Crematory		22d. LOCATION (City, town, or county) (State) Wash. D. C.					
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lees						ADDRESS Wash. D. C.		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma		24c. REC'D BY REGISTRAR DATE DEC 2 '58			

CERTIFICATE OF DEATH

Eng. No. 100

12778

<p>1. NAME OF DECEASED JAMES H. HARRIS</p>		<p>2. SEX Male</p>		<p>3. AGE 65</p>		<p>4. DATE OF BIRTH 1872</p>		<p>5. PLACE OF BIRTH New York</p>	
<p>6. OCCUPATION Farmer</p>		<p>7. CAUSE OF DEATH Heart Disease</p>		<p>8. MANNER OF DEATH Natural</p>		<p>9. DATE OF DEATH 1937</p>		<p>10. PLACE OF DEATH Home</p>	
<p>11. SIGNATURE OF DECEASED (Signature)</p>		<p>12. SIGNATURE OF WITNESS (Signature)</p>		<p>13. SIGNATURE OF DECEASED (Signature)</p>		<p>14. SIGNATURE OF WITNESS (Signature)</p>		<p>15. SIGNATURE OF DECEASED (Signature)</p>	
<p>16. SIGNATURE OF WITNESS (Signature)</p>		<p>17. SIGNATURE OF DECEASED (Signature)</p>		<p>18. SIGNATURE OF WITNESS (Signature)</p>		<p>19. SIGNATURE OF DECEASED (Signature)</p>		<p>20. SIGNATURE OF WITNESS (Signature)</p>	
<p>21. SIGNATURE OF DECEASED (Signature)</p>		<p>22. SIGNATURE OF WITNESS (Signature)</p>		<p>23. SIGNATURE OF DECEASED (Signature)</p>		<p>24. SIGNATURE OF WITNESS (Signature)</p>		<p>25. SIGNATURE OF DECEASED (Signature)</p>	
<p>26. SIGNATURE OF WITNESS (Signature)</p>		<p>27. SIGNATURE OF DECEASED (Signature)</p>		<p>28. SIGNATURE OF WITNESS (Signature)</p>		<p>29. SIGNATURE OF DECEASED (Signature)</p>		<p>30. SIGNATURE OF WITNESS (Signature)</p>	
<p>31. SIGNATURE OF DECEASED (Signature)</p>		<p>32. SIGNATURE OF WITNESS (Signature)</p>		<p>33. SIGNATURE OF DECEASED (Signature)</p>		<p>34. SIGNATURE OF WITNESS (Signature)</p>		<p>35. SIGNATURE OF DECEASED (Signature)</p>	
<p>36. SIGNATURE OF WITNESS (Signature)</p>		<p>37. SIGNATURE OF DECEASED (Signature)</p>		<p>38. SIGNATURE OF WITNESS (Signature)</p>		<p>39. SIGNATURE OF DECEASED (Signature)</p>		<p>40. SIGNATURE OF WITNESS (Signature)</p>	
<p>41. SIGNATURE OF DECEASED (Signature)</p>		<p>42. SIGNATURE OF WITNESS (Signature)</p>		<p>43. SIGNATURE OF DECEASED (Signature)</p>		<p>44. SIGNATURE OF WITNESS (Signature)</p>		<p>45. SIGNATURE OF DECEASED (Signature)</p>	
<p>46. SIGNATURE OF WITNESS (Signature)</p>		<p>47. SIGNATURE OF DECEASED (Signature)</p>		<p>48. SIGNATURE OF WITNESS (Signature)</p>		<p>49. SIGNATURE OF DECEASED (Signature)</p>		<p>50. SIGNATURE OF WITNESS (Signature)</p>	
<p>51. SIGNATURE OF DECEASED (Signature)</p>		<p>52. SIGNATURE OF WITNESS (Signature)</p>		<p>53. SIGNATURE OF DECEASED (Signature)</p>		<p>54. SIGNATURE OF WITNESS (Signature)</p>		<p>55. SIGNATURE OF DECEASED (Signature)</p>	
<p>56. SIGNATURE OF WITNESS (Signature)</p>		<p>57. SIGNATURE OF DECEASED (Signature)</p>		<p>58. SIGNATURE OF WITNESS (Signature)</p>		<p>59. SIGNATURE OF DECEASED (Signature)</p>		<p>60. SIGNATURE OF WITNESS (Signature)</p>	
<p>61. SIGNATURE OF DECEASED (Signature)</p>		<p>62. SIGNATURE OF WITNESS (Signature)</p>		<p>63. SIGNATURE OF DECEASED (Signature)</p>		<p>64. SIGNATURE OF WITNESS (Signature)</p>		<p>65. SIGNATURE OF DECEASED (Signature)</p>	
<p>66. SIGNATURE OF WITNESS (Signature)</p>		<p>67. SIGNATURE OF DECEASED (Signature)</p>		<p>68. SIGNATURE OF WITNESS (Signature)</p>		<p>69. SIGNATURE OF DECEASED (Signature)</p>		<p>70. SIGNATURE OF WITNESS (Signature)</p>	
<p>71. SIGNATURE OF DECEASED (Signature)</p>		<p>72. SIGNATURE OF WITNESS (Signature)</p>		<p>73. SIGNATURE OF DECEASED (Signature)</p>		<p>74. SIGNATURE OF WITNESS (Signature)</p>		<p>75. SIGNATURE OF DECEASED (Signature)</p>	
<p>76. SIGNATURE OF WITNESS (Signature)</p>		<p>77. SIGNATURE OF DECEASED (Signature)</p>		<p>78. SIGNATURE OF WITNESS (Signature)</p>		<p>79. SIGNATURE OF DECEASED (Signature)</p>		<p>80. SIGNATURE OF WITNESS (Signature)</p>	
<p>81. SIGNATURE OF DECEASED (Signature)</p>		<p>82. SIGNATURE OF WITNESS (Signature)</p>		<p>83. SIGNATURE OF DECEASED (Signature)</p>		<p>84. SIGNATURE OF WITNESS (Signature)</p>		<p>85. SIGNATURE OF DECEASED (Signature)</p>	
<p>86. SIGNATURE OF WITNESS (Signature)</p>		<p>87. SIGNATURE OF DECEASED (Signature)</p>		<p>88. SIGNATURE OF WITNESS (Signature)</p>		<p>89. SIGNATURE OF DECEASED (Signature)</p>		<p>90. SIGNATURE OF WITNESS (Signature)</p>	
<p>91. SIGNATURE OF DECEASED (Signature)</p>		<p>92. SIGNATURE OF WITNESS (Signature)</p>		<p>93. SIGNATURE OF DECEASED (Signature)</p>		<p>94. SIGNATURE OF WITNESS (Signature)</p>		<p>95. SIGNATURE OF DECEASED (Signature)</p>	
<p>96. SIGNATURE OF WITNESS (Signature)</p>		<p>97. SIGNATURE OF DECEASED (Signature)</p>		<p>98. SIGNATURE OF WITNESS (Signature)</p>		<p>99. SIGNATURE OF DECEASED (Signature)</p>		<p>100. SIGNATURE OF WITNESS (Signature)</p>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12779 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12778

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 6 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3605 Chevy Chase Lake Dr.				d. STREET ADDRESS 3605 Chevy Chase Lake Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Desmond Joseph Ward				4. DATE OF DEATH Month Day Year Nov. 4, 1958 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/1904		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days 1 5	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) realtor		10b. KIND OF BUSINESS OR INDUSTRY self-employed		11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph S. Ward				14. MOTHER'S MAIDEN NAME ? Garity			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes After WWI		16. SOCIAL SECURITY NO. 212-24-4451		17. INFORMANT Frances D. Ward (wife)		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Found dead in bed						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Nov. 4, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/7/58		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR NOV 6 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

1977

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, First, Middle Initial) JOHN J. BROWN		2. SEX Male	
3. DATE OF BIRTH 01/15/1925		4. PLACE OF BIRTH Boston, Massachusetts	
5. SOCIAL SECURITY NUMBER 01-123456789		6. OCCUPATION Retired	
7. MARITAL STATUS Married		8. EDUCATION High School Graduate	
9. PRESENT RESIDENCE 123 Main St., Boston, MA 02101		10. DATE OF DEATH 11/15/1977	
11. CAUSE OF DEATH (Immediate) Myocardial Infarction		12. MANNER OF DEATH Natural	
13. UNDERLYING CAUSE OF DEATH (Final) Coronary Atherosclerosis		14. SIGNATURE OF MEDICAL EXAMINER [Signature]	
15. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		16. SIGNATURE OF WITNESS [Signature]	
17. SIGNATURE OF REGISTRAR [Signature]		18. OFFICIAL SEAL [Seal]	

TO BE FILLED IN BY THE MEDICAL EXAMINER

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>19 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>				d. STREET ADDRESS <i>16815 Red Top Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Louis</i> Middle <i>None</i> Last <i>Weiner</i>				4. DATE OF DEATH Month <i>11</i> - Day <i>16</i> - Year <i>1958</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-10-77</i>	
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months <i>8</i> Days <i>1</i> Hours <i>1</i> Min.		IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Manufacturer</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Canada</i>				13. FATHER'S NAME <i>Jacob Weiner</i>			
14. MOTHER'S MAIDEN NAME <i>unknown</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <i>Washington Sanitarium & Hospital/Reed</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of rectum</i> <i>154X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <i>October 26, 1958</i> , to <i>November 16, 1958</i> , that I last saw the deceased alive on <i>November 13, 1958</i> , and that death occurred at <i>1:35 P.M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Boris Rabkin</i> M.D. ADDRESS (Street, city or town, state) <i>1019 University Boulevard</i> DATE SIGNED <i>11/16/58</i> PHYSICIAN'S NAME (Type) <i>BORIS RABKIN</i> <i>Silver Spring, Maryland</i> 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> 22b. DATE THEREOF <i>11/18/58</i> 22c. NAME OF CEMETERY OR CREMATORY <i>Adath Yeshurun Cem.</i> 22d. LOCATION (City, town, or county) (State) <i>Montreal, Canada</i> 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>3506-14th St. N.W.</i> 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <i>A. Dargatzis & Sons Wash., D.C.</i> DATE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 18 '58

C. L. E. K. K. K.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12780
CERTIFICATE OF DEATH

12780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>92 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>8</u> <u>03x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			d. STREET ADDRESS <u>3501 Northridge Drive</u>		
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Freda</u> Last <u>Weiss</u>			4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1908</u>		9. AGE (In years last birthday) <u>50</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Samuel Collector</u>			14. MOTHER'S MAIDEN NAME <u>Leah Berkowich</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>053.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>491X</u> (b) <u>Bronchopneumonia and Hepato Splenomegaly</u> DUE TO (c) <u>Staphylococcal Infection</u>						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subacute Cerebral Degeneration of Heidenhain</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 2, 1958</u> to <u>November 2, 1958</u> , that I last saw the deceased alive on <u>November 2, 1958</u> , and that death occurred at <u>8:35 P.M.</u> from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Bushnell Smith MD</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u>				DATE SIGNED <u>11/3/58</u>			
PHYSICIAN'S NAME (Type) <u>BUSHNELL SMITH, M.D.</u>				National Institutes of Health				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-4-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Hebrew</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc - 2100 Eutaw Place</u>						ADDRESS		24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12781

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 62 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Tennessee b. COUNTY Chattanooga 79x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eva Middle Nell Last White		4. DATE OF DEATH Month November Day 22 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1931
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Raymond L. Sims		14. MOTHER'S MAIDEN NAME Eula Hulsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 118-24-1779	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest in postoperative period 410x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prolonged hypotension postoperatively DUE TO Rheumatic Heart Disease (c) Coronary insufficiency + arteriosclerosis + aortic insufficiency			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 21, 19 58 , to November 22, 19 58 , that I last saw the deceased alive on November 22, 19 58 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-23-58 ACTUAL SIGNATURE William P. Cornell M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) William P. Cornell, M. D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, or other disposal (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial-transit 11-23-58		Fuller Cemetery	DeKalb Co., Id., Alabama
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE NOV 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

1

12782

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 6300 Wisconsin Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Grady Baskin WHITEHEAD				4. DATE OF DEATH Month Day Year November 1 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-20-89	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Beeland WHITEHEAD				14. MOTHER'S MAIDEN NAME Anna E. SPIVEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. WWI - WWII		17. INFORMANT None		Address Official Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aneurysm 451x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 hours unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bleeding diathesis due to autogenous circulating anti-coagulant - 6mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 12 , 19 58 , to November 1 , 19 58 , (that I last saw the deceased alive on October 31 , 19 58 , and that death occurred at 4:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NNMC 11-1-58							
ACTUAL SIGNATURE J. T. Horgan		M.D. U. S. Naval Hospital, NNMC 11-1-58					
PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR, MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-4-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, Bethesda, Md.				24a. REC'D BY REGISTRAR DATE NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1973

Married

White

U.S. Army

1973

(Date)

1000 Wisconsin Ave.

U.S. Army Hospital

November

1973

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U.S.A.

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U.S. Army

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12783

CERTIFICATE OF DEATH

12783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane Nursing Home</u>		d. STREET ADDRESS <u>3411 Oakwood Lnw. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDSON LEONE WHITNEY</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 26 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-61</u>
9. AGE (In years last birthday) yrs. <u>97</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Translator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Fredric Whitney</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mariani</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Clifford Whitney</u>		Address <u>3411 Oakwood Lnw. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC MYOCARDITIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 6, 1957</u> , to <u>Nov. 26, 1958</u> , that I last saw the deceased alive on <u>Nov. 26, 1958</u> , and that death occurred at <u>10:02 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 Newway Dr. Chevy Chase, Md.</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>		DATE SIGNED <u>11/26/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-29-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crested Lake Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Gardner, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers & Co Inc</u> ADDRESS <u>1400 Chapin St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CLERK</p>		<p>16. SIGNATURE OF REGISTRAR</p>	
<p>17. SIGNATURE OF JUDGE</p>		<p>18. SIGNATURE OF SHERIFF</p>		<p>19. SIGNATURE OF CORONER</p>		<p>20. SIGNATURE OF JURY</p>	
<p>21. SIGNATURE OF JURY</p>		<p>22. SIGNATURE OF JURY</p>		<p>23. SIGNATURE OF JURY</p>		<p>24. SIGNATURE OF JURY</p>	
<p>25. SIGNATURE OF JURY</p>		<p>26. SIGNATURE OF JURY</p>		<p>27. SIGNATURE OF JURY</p>		<p>28. SIGNATURE OF JURY</p>	
<p>29. SIGNATURE OF JURY</p>		<p>30. SIGNATURE OF JURY</p>		<p>31. SIGNATURE OF JURY</p>		<p>32. SIGNATURE OF JURY</p>	
<p>33. SIGNATURE OF JURY</p>		<p>34. SIGNATURE OF JURY</p>		<p>35. SIGNATURE OF JURY</p>		<p>36. SIGNATURE OF JURY</p>	
<p>37. SIGNATURE OF JURY</p>		<p>38. SIGNATURE OF JURY</p>		<p>39. SIGNATURE OF JURY</p>		<p>40. SIGNATURE OF JURY</p>	
<p>41. SIGNATURE OF JURY</p>		<p>42. SIGNATURE OF JURY</p>		<p>43. SIGNATURE OF JURY</p>		<p>44. SIGNATURE OF JURY</p>	
<p>45. SIGNATURE OF JURY</p>		<p>46. SIGNATURE OF JURY</p>		<p>47. SIGNATURE OF JURY</p>		<p>48. SIGNATURE OF JURY</p>	
<p>49. SIGNATURE OF JURY</p>		<p>50. SIGNATURE OF JURY</p>		<p>51. SIGNATURE OF JURY</p>		<p>52. SIGNATURE OF JURY</p>	
<p>53. SIGNATURE OF JURY</p>		<p>54. SIGNATURE OF JURY</p>		<p>55. SIGNATURE OF JURY</p>		<p>56. SIGNATURE OF JURY</p>	
<p>57. SIGNATURE OF JURY</p>		<p>58. SIGNATURE OF JURY</p>		<p>59. SIGNATURE OF JURY</p>		<p>60. SIGNATURE OF JURY</p>	
<p>61. SIGNATURE OF JURY</p>		<p>62. SIGNATURE OF JURY</p>		<p>63. SIGNATURE OF JURY</p>		<p>64. SIGNATURE OF JURY</p>	
<p>65. SIGNATURE OF JURY</p>		<p>66. SIGNATURE OF JURY</p>		<p>67. SIGNATURE OF JURY</p>		<p>68. SIGNATURE OF JURY</p>	
<p>69. SIGNATURE OF JURY</p>		<p>70. SIGNATURE OF JURY</p>		<p>71. SIGNATURE OF JURY</p>		<p>72. SIGNATURE OF JURY</p>	
<p>73. SIGNATURE OF JURY</p>		<p>74. SIGNATURE OF JURY</p>		<p>75. SIGNATURE OF JURY</p>		<p>76. SIGNATURE OF JURY</p>	
<p>77. SIGNATURE OF JURY</p>		<p>78. SIGNATURE OF JURY</p>		<p>79. SIGNATURE OF JURY</p>		<p>80. SIGNATURE OF JURY</p>	
<p>81. SIGNATURE OF JURY</p>		<p>82. SIGNATURE OF JURY</p>		<p>83. SIGNATURE OF JURY</p>		<p>84. SIGNATURE OF JURY</p>	
<p>85. SIGNATURE OF JURY</p>		<p>86. SIGNATURE OF JURY</p>		<p>87. SIGNATURE OF JURY</p>		<p>88. SIGNATURE OF JURY</p>	
<p>89. SIGNATURE OF JURY</p>		<p>90. SIGNATURE OF JURY</p>		<p>91. SIGNATURE OF JURY</p>		<p>92. SIGNATURE OF JURY</p>	
<p>93. SIGNATURE OF JURY</p>		<p>94. SIGNATURE OF JURY</p>		<p>95. SIGNATURE OF JURY</p>		<p>96. SIGNATURE OF JURY</p>	
<p>97. SIGNATURE OF JURY</p>		<p>98. SIGNATURE OF JURY</p>		<p>99. SIGNATURE OF JURY</p>		<p>100. SIGNATURE OF JURY</p>	

12784

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 63 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Lancaster e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Eugene Last Wiegand		4. DATE OF DEATH Month November Day 11 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1953
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months 11 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Peter F. Wiegand		14. MOTHER'S MAIDEN NAME Dorothy Stockbauer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Pneumonia and Septicemia 203.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphocytic Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH days mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 9, 1958 , to November 11, 1958 , that I last saw the deceased alive on November 11, 1958 , and that death occurred at 1:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-11-58			
ACTUAL SIGNATURE Paul J. Schwab, M.D.		PHYSICIAN'S NAME (Type) Paul J. Schwab, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial-Transit	11/14/58	St. Joseph's Cem. (New)	Lancaster, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE NOV 14 '58		24b. REGISTRAR'S SIGNATURE Carlton L. Haines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12785

CERTIFICATE OF DEATH

12785

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b X Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 25 Hesketh Street				d. STREET ADDRESS 25 Hesketh Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MAUDE L. WILLIS First Middle Last				4. DATE OF DEATH Nov. 29, Month Day Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1870	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR 5 Months 14 Days		IF UNDER 24 HRS. 14 Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT W. F. Cross-Item # 2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Generalized arteriosclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Generalized arteriosclerosis. DUE TO (c) Generalized arteriosclerosis.							INTERVAL BETWEEN ONSET AND DEATH 20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1956 to Present , 19 58 , that I last saw the deceased alive on 11/10 , 19 58 , and that death occurred at 3:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald Q. Ekman		M.D. 5707 Wisconsin Ave		ADDRESS (Street, city or town, state)		DATE SIGNED 11/29/58	
PHYSICIAN'S NAME (Type) Donald Q. Ekman		5707 Wisconsin Avenue,					
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 12/3/58		22c. NAME OF CEMETERY OR CREMATORY Uniontown		22d. LOCATION (City, town, or county) (State) Uniontown, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 3 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. MONTANA—HATCHED THE PASTORAL CHAIRS

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1529 Beall Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nape Leon</u>		4. DATE OF DEATH Month Day Year <u>Nov. 16 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/4/92</u>
9. AGE (In years last birthdys) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navystad</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>un known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-5813</u>	
17. INFORMANT <u>Cornelia Willis - same as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>B rain tumor, (glioma), involving frontal</u> DUE TO <u>poli</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X Bronchopneumonia, bilateral, involving both lower lobes</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 5</u> , 1958, to <u>Nov. 16</u> , 1958, that I lost sow the deceased alive on <u>Nov. 15</u> , 1958, and that death occurred at <u>3:25 AM</u> , from the causes ond on the date stoted above.			
ACTUAL SIGNATURE <u>Robert G. Angle</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5009 Del Ray Ave, Bethesda, 11/16/58</u>	
PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		<u>5009 DelRay Ave. Bethesda, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DANOV 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12786

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. OCCUPATION [Illegible]</p>	
<p>7. MARITAL STATUS [Illegible]</p>		<p>8. CAUSE OF DEATH [Illegible]</p>	
<p>9. PLACE OF DEATH [Illegible]</p>		<p>10. DATE OF DEATH [Illegible]</p>	
<p>11. SIGNATURE OF DECEASED [Illegible]</p>		<p>12. SIGNATURE OF WITNESS [Illegible]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>14. SIGNATURE OF CORONER [Illegible]</p>	
<p>15. SIGNATURE OF JURY [Illegible]</p>		<p>16. SIGNATURE OF JUDGE [Illegible]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 9 Film 235 11-18-58 et

12788

CERTIFICATE OF DEATH

12788

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery Co - Md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery - Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Cherry Chase - Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3806 Williams Lane</u>		d. STREET ADDRESS <u>13806 Williams Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Theodora</u> First <u>Marianne</u> Middle <u>Wigman</u> Last <u>Booth</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24 - 1868</u>
9. AGE (In years last birthday) <u>140 yrs.</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>16</u> IF UNDER 24 HRS. Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Toronto, Canada.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Wood Booth</u>		14. MOTHER'S MAIDEN NAME <u>Clara Louise Irene Gaghier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Edith W. Masters</u>		Address <u>3806 Vmstare Cherry Chase - Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive heart failure and</u> DUE TO (c) <u>myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>51</u> , to <u>10 Nov</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10 Nov</u> , 19 <u>58</u> , and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5029 Bethesda Ave</u> DATE SIGNED <u>10 Nov 58</u>			
ACTUAL SIGNATURE <u>Herbert Martyn Jr.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR.</u>		<u>Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Nov 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF BIRTH [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH [Faint handwritten place]</p>		<p>6. OCCUPATION [Faint handwritten occupation]</p>	
<p>7. MARITAL STATUS [Faint handwritten status]</p>		<p>8. CAUSE OF DEATH [Faint handwritten cause]</p>	
<p>9. MEDICAL HISTORY [Faint handwritten history]</p>		<p>10. DATE OF DEATH [Faint handwritten date]</p>	
<p>11. PLACE OF DEATH [Faint handwritten place]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>	
<p>13. SIGNATURE OF WITNESS [Faint handwritten signature]</p>		<p>14. SIGNATURE OF DECEASED [Faint handwritten signature]</p>	
<p>15. SIGNATURE OF REGISTRAR [Faint handwritten signature]</p>		<p>16. SIGNATURE OF CLERK [Faint handwritten signature]</p>	

12789

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orlando 48x-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First Mary Middle E Last Woodford			4. DATE OF DEATH Month November Day 9 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 15, 1872	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home work		11. BIRTHPLACE (State or foreign country) Queen Ann Co., Md.	
13. FATHER'S NAME E. B. Van Dyke			14. MOTHER'S MAIDEN NAME Mary E. Shaw		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Asbury Methodist Home Records, Gaithersburg Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unemia 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular accident DUE TO (c) Arteriosclerosis generalized					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 12-28 , 19 58 , to 11-9 , 19 58 , that I last saw the deceased alive on 11-8 , 19 58 , and that death occurred at 9 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Sarah E. Glover M.D. 4208 Anthony St Kensington, Md 11-9-58 PHYSICIAN'S NAME (Type) Sarah E. Glover, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-12-58	22c. NAME OF CEMETERY OR CREMATORY Centerville	22d. LOCATION (City, town, or county) (State) Centerville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.			24a. REC'D BY REGISTRAR DATE NOV 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12790

12790

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville, Silver Spring		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 706 Orchard Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOLA Middle H. Last WOOTTON		4. DATE OF DEATH Month NOV. Day 29 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/23/11
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11. BIRTHPLACE (State or foreign country) Prosperity, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Haddock		14. MOTHER'S MAIDEN NAME Mary Ann Martha Wootton CREWSE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-14-4181	
17. INFORMANT Mr. Norman D. Wootton, 706 Orchard Way		Address Colesville, S. S. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 19 56 , to Nov. 29, 19 58 , that I last saw the deceased alive on Nov. 29, 19 58 , and that death occurred at 4:00 A. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Marion B. Binkhead M.D.		ADDRESS (Street, city or town, state) 9241 Col. Blvd. DATE SIGNED Nov 29, 19 58	
PHYSICIAN'S NAME (Type) J. Marion Binkhead		Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/2/58	
22c. NAME OF CEMETERY OR CREMATORY MONOCACY CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Gaska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE DEC 4 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12791
CERTIFICATE OF DEATH

12791

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 8 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			e. STREET ADDRESS 54 Broad Street		
3. NAME OF DECEASED (Type or print) First Howard Middle Lewis Last Wright			4. DATE OF DEATH Month November Day 10 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1911		9. AGE (In years last birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania
13. FATHER'S NAME James Wright			14. MOTHER'S MAIDEN NAME Louise M. Christy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 186-03-9045	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive hemorrhage and cardiac fibrillation - during surgery DUE TO transventricular aortic valvulotomy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Calcarific aortic stenosis + insufficiency DUE TO ? Congenital PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from November 2, 1958 , to November 10, 1958 , that I last saw the deceased alive on November 10, 1958 , and that death occurred at 11:20 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE H. Perryman Collins M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 11-10-58	
PHYSICIAN'S NAME (Type) N. Perryman Collins, M. D.		National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 14 Nov. 1958	22c. NAME OF CEMETERY OR CREMATORY Silverbrook		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.			24a. REC'D BY REGISTRAR NOV 13 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF DELAWARE DEPARTMENT OF HEALTH

Robert A. Humphrey - Bethesda, Md.

Chronicity - 1- Nov. 1955 - Silverbrook

Wilmington, Delaware

Official Certificate of Death

Have not yet 50th birthday

Official Certificate of Death

Official Certificate of Death

Official Certificate of Death

Official Certificate of Death

Official Certificate of Death

Official Certificate of Death

Official Certificate of Death

12792

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>120 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u> <u>83 x 3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>1410 W. 37th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>Ray</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 1, 1954</u>	
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (Child)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Elmer Joseph Wright</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Mae Edwards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMATION <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Walden's tumor</u> <u>180x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 16</u> , 19 <u>58</u> , to <u>November 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>November 13</u> , 19 <u>58</u> , and that death occurred at <u>3:20 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/13/58</u> ACTUAL SIGNATURE <u>Richard Lee</u> M.D. <u>National Institutes of Health</u> PHYSICIAN'S NAME (Type) <u>G. Richard Lee, M. D.</u> <u>Bethesda 14, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>14 Nov. 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Norfolk, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>				ADDRESS <u>4410 W. 37th St. Wash DC</u>		24a. REC'D BY REGISTRAR <u>Nov 17 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

595

12793

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>125 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Chester (none) Zuchelli</u>				4. DATE OF DEATH Month Day Year <u>November 22, 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15, 1886</u>	
9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>5 7</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>(Unknown) Zuchelli</u>				14. MOTHER'S MAIDEN NAME <u>Cecilia Briosi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WW I</u>				16. SOCIAL SECURITY NO. <u>Unavailable</u>			
17. INFORMANT <u>The Medical Record Address</u> <u>The Clinical Center, Bethesda 14, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>191.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Carcinoma of neck (epidermoid)</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>30 days</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) <u>491X</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Jefferson County, Penn.</u>				(County) (State)			
21. I certify that I attended the deceased from <u>July 20, 1958</u> , to <u>November 22, 1958</u> , that I last saw the deceased alive on <u>November 22, 1958</u> , and that death occurred at <u>10:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u> DATE SIGNED <u>11-22-58</u>							
ACTUAL SIGNATURE <u>Theodore L. Goodfriend</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Theodore L. Goodfriend, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>11/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reynoldsville</u>		22d. LOCATION (City, town, or county) (State) <u>Jefferson County, Penn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

